DISPUTE RESOLUTION PRACTICE CODE

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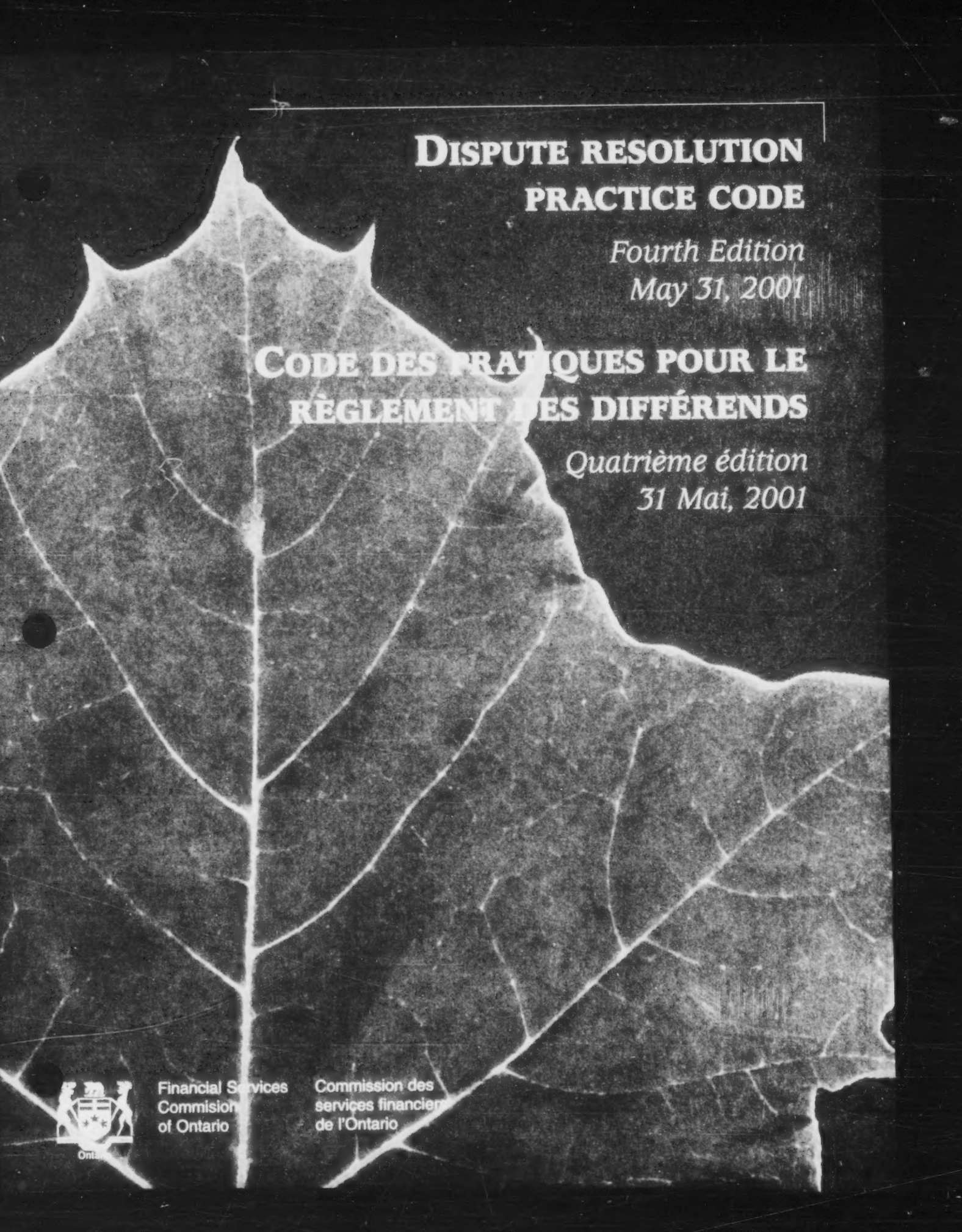

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

Financial Services Commission

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INTRODUCTION

The **Dispute Resolution Practice Code ("Code")** is a user's guide to resolving disputes between consumers and insurers involving statutory accident benefits claims under the *Insurance Act* and the *Statutory Accident Benefits Schedule ("SABS")*.

The **Code** is published by the Dispute Resolution Group of the **Financial Services Commission of Ontario** ("FSCO" or the "Commission"). Although there have been previous editions of the **Code**, this edition is the first published by the Dispute Resolution Group as part of FSCO.

FSCO is responsible for regulating the insurance sector as well as other financial service sectors in Ontario, namely, pensions, credit unions and caisses populaires, cooperatives, mortgage brokers and the loan and trust sectors. It is an arm's-length agency of the Ministry of Finance. FSCO provides regulatory and direct services that protect the public interest and enhance public confidence in the regulated sectors.

FSCO was established on July 1, 1998, under the *Financial Services Commission of Ontario Act, 1997*. It amalgamated the operations of the former Ontario Insurance Commission, the Pension Commission of Ontario and the Deposit Institutions Division of the Ministry of Finance.

The **Code** creates rules for timely, cost-effective and fair dispute resolution services provided through FSCO's Dispute Resolution Group. The rules of procedure in this **Code** apply to new applications as well as cases already in progress. The rules have been made after extensive consultations with users of the dispute resolution system.

THE SERVICES OF THE DISPUTE RESOLUTION GROUP

The Dispute Resolution Group at the Commission provides mediation, neutral evaluation and arbitration services. There is also a process for appealing arbitration orders on a question of law, and a process for varying or revoking orders.

If consumers and insurers are unable to resolve disputes about statutory accident benefits, the first step in the dispute resolution process is mediation. Mediation of such disputes is mandatory in Ontario and must be conducted through the Commission before the dispute can proceed to arbitration or court. The insured person is charged no fee for mediation. However, each party must pay for its own expenses, which may include lawyer's fees, travelling expenses, accounting services, and additional medical reports.

Mediation is an informal process in which a mediator helps parties involved in a dispute to clarify issues and find solutions that lead to a satisfactory outcome. The Mediation Unit of the Dispute Resolution Group has established a successful record in mediation, achieving full or partial success in over 75 percent of mediations. In December 1998, the Unit was awarded the prestigious Amethyst Award for outstanding achievement by the Ontario Public Service.

If the dispute remains unresolved after mediation at the Commission, the insured person has a number of choices. He or she can continue to negotiate directly with the insurance company. Alternatively, the insured person can opt for arbitration at

the Commission, private arbitration, private neutral evaluation or a court action. Each option has its own rules, and the insured person may not be able to switch from one system to another. For example, once an action has been commenced in court, the insured person may not be able to switch to arbitration at the Commission, or vice versa.

ABOUT THIS CODE

This **Code** will help the parties move through the Commission's dispute resolution process. It explains what is required of everyone involved and sets out rules for such matters as the filing of documents, time limits and payment of fees and expenses. Of particular importance are the rights and responsibilities of insurers and claimants when dealing with statutory accident benefits claims. These rights and responsibilities are outlined in **Guidelines B 2-1 and B 3-1**, which may be found in **Section B** of the **Code.**

It is important to note that the specific types of benefits, amounts, and eligibility requirements for benefits, will differ depending on when the motor vehicle accident took place.

If the accident occurred:	**The applicable legislation is:**
• on or after November 1, 1996	• *Insurance Act*, R.S.O. 1990, c.I.8, as amended, including amendments under the *Automobile Insurance Rate Stability Act*, 1996 [AIRSA], also known as **Bill 59**; and • *Statutory Accident Benefits Schedule – Accidents On or After November 1, 1996*, Ontario Regulation 423/96, as amended [referred to generally as *SABS*].
• on or between January 1, 1994 and October 31, 1996	• *Insurance Act*, R.S.O. 1990, c.I.8, as amended by the *Insurance Statute Law Amendment Act*, 1993, also known as **Bill 164**; and • *Statutory Accident Benefits Schedule – Accidents After December 31, 1993 and Before November 1, 1996*, Ontario Regulation 776/93, as amended [referred to generally as *SABS*].
• on or between June 22, 1990 and December 31, 1993	• *Insurance Act*, R.S.O. 1980, c.218, as amended by the *Insurance Statute Law Amendment Act*, 1990, and consolidated by the *Insurance Act*, R.S.O. 1990, c.I.8, also known as the *Ontario Motorist Protection Plan ("OMPP")* or **Bill 68**; and • *Statutory Accident Benefits Schedule – Accidents Before January 1, 1994*, Ontario Regulation 672/90, as amended [referred to generally as *SABS*].

These rules DO NOT apply if the accident occurred on or **before** june 21, 1990.

If any provision of the **Code** is found to be contrary to the *Insurance Act* or any other law, then that law will prevail.

HOW THIS CODE IS ORGANIZED

The **Code** has been divided into 7 sections.

Section A, the **Rules of Procedure**, consists of General Rules for Dispute Resolution at the Commission: Mediation, Arbitration, Neutral Evaluation, Appeal of an Arbitration Order, Variation or Revocation of an Order, as well as General Procedures for Hearings.

Section B contains **Guidelines** issued by the Superintendent of Financial Services and the former Commissioner of the Ontario Insurance Commission on the interpretation and operation of the *SABS*.[1]

Section C contains **Practice Notes**, which are issued by the Dispute Resolution Group to explain key elements of the dispute resolution process.

Section D sets out the applicable **fees and assessments** during the process.

Sections E and **F** contain the **regulations on settlements and expenses**, respectively.

Section G has copies of all the required **forms**.

For general information on mediation, neutral evaluation, arbitration, appeal, and variation/revocation, see **"Some Answers to Frequently Asked Questions [FAQS] by Claimants",** which may be found in this **Introduction** section.

The **Code** is designed to fit a 1 1/2-inch or 2 1/2-inch round ring binder with a clear insert sleeve on the front and spine of the binder. The pages have been three-hole punched to allow for easy insertion of updates. These updates will be issued periodically as the need arises.

[1]This section includes guidelines issued by the Financial Services Commission of Ontario's (FSCO) predecessor, the Ontario Insurance Commission, as well as FSCO, and may make reference to the Ontario Insurance Commission and/or the Commissioner. Where reference is made to the Ontario Insurance Commission and/or Commissioner, these should be read as Financial Services Commissioner of Ontario and/or Superintendent.

WHERE TO OBTAIN ADDITIONAL COPIES OF THIS CODE, DISPUTE RESOLUTION FORMS, AND DECISIONS ISSUED BY THE DISPUTE RESOLUTION GROUP

Additional copies of the **Code** and updates may be purchased from:

Publications Ontario
880 Bay Street
Toronto ON M7A 1N8
Phone: (416) 326-5300
1-800-668-9938 (toll-free)

Other outlets interested in selling the **Code** should contact the Director of Arbitrations at the address for the Dispute Resolution Group set out below.

The complete **Code**, as well as an updated list of all outlets selling the **Code**, is maintained on the FSCO website at **www.fsco.gov.on.ca**. The **Code** can also be found at major public libraries, and in legal publications which report the decisions of the Dispute Resolution Group.

The complete text of decisions issued by the Arbitration and Appeals Units of the Commission are posted on FSCO's website at **www.fsco.gov.on.ca**. Access to the decisions is a secure site. To obtain a password, please contact the Dispute Resolution Hotline at phone number (416) 590-7202 or 1-800-517-2332 (toll-free), ext. 7202.

Summaries and commentaries of decisions issued by the Arbitration and Appeal Units of the Dispute Resolution Group are published in the legal publications and computer services listed below. Please contact the provider directly to determine any cost associated with the use of these legal summaries or computer services.

Financial Services Commission of Ontario (Motor Vehicle Insurance) Law & Practice, James M. Flaherty and Catherine H. Zingg, eds. (Canada Law Book Inc., Aug. 2001)
Canada Law Book Inc.
240 Edward Street
Aurora ON L4G 3S9
Fax: (905) 841-5085
Sales Only (Toll Free): 1-800-263-3269 or
1-800-263-2037
Case Law on Call: 1-800-565-6967

No Fault Arbitration Manual, Ontario,
Robert A. Robinson and Harry P. Brown, eds. (Scarborough, Ont. Carswell, 2000 3 vols.)
1 Corporate Plaza
2075 Kennedy Road
Scarborough ON M1T 3V4
Fax: (416) 298-5082
Phone: (416) 609-3800
E-mail: customercare@carswell.com
Website: <**www.carswell.com**>

Ontario Accident Benefits Case Summaries,
Eric K. Grossman, ed. (CCH Canadian Ltd., 1999)
90 Sheppard Avenue East, Suite 300
North York ON M2N 6X1
Fax: (416) 224-2243;
Phone: (416) 224-2224;
1-800-461-5308,
1-800-461-4131
For outside Toronto, phone 1-800-387-5164

QUICKLAW Computer Reporting Services,
1 First Canadian Place, Suite 930
Box 235
Toronto ON M5X 1C8
Fax: (416) 862-8073
Phone: (416) 862-7656
For outside Toronto, phone 1-800-387-0899

An Application for mediation, arbitration, appeal or variation/revocation may be obtained from your insurance company. If you are having difficulty obtaining a form, you may download a single copy from **Section G** of the **Code** posted on FSCO's website at **www.fsco.gov.on.ca** or you may write or telephone the Dispute Resolution Group to have a single copy sent to you, as noted below. The mailing address for all forms is:

Financial Services Commission of Ontario
Dispute Resolution Group
5160 Yonge Street, P.O. Box 85
Toronto ON M2N 6L9

Please specify whether you are seeking a mediation, arbitration or appeal form.

Or, telephone or fax your request for an application pertaining to:

Mediation:
Phone: (416) 250-6714 ext. 7210,
1-800-517-2332 (toll-free), ext. 7210
Fax: (416) 590-7077

Arbitration or Neutral Evaluation:
Phone: (416) 590-7202
1-800-517-2332 (toll-free), ext. 7202
Fax: (416) 590-8462

Appeal, Variation or Revocation:
Phone: (416) 590-7222
1-800-517-2332 (toll-free), ext. 7222
Fax: (416) 590-7077

Bulk orders of forms are available from printers such as:

Informco Inc.
35 Bertrand Avenue
Scarborough ON M1L 2P3
Phone: (416) 285-1700

Datamark Systems
3880 Nashua Drive
Mississauga ON L4V 1M5
Phone: (905) 678-3301, 1-800-361-3263

Optus Art & Logic
4195 Dundas Street West, Unit 1
Etobicoke ON M8X 1Y4
Phone: (416) 236-8777

Proprint Forms
5621 Finch Avenue East, Unit 5
Scarborough ON M1B 2T9
Phone: (416) 754-3028

SOME ANSWERS TO FREQUENTLY ASKED QUESTIONS [FAQS] BY CLAIMANTS

What disputes can be brought to the Dispute Resolution Group at the Commission?

Our services help resolve disputes about whether or not you qualify for benefits under the *Statutory Accident Benefits Schedule (SABS)*, and how much those benefits should be. You may use the services of the Dispute Resolution Group if an accident benefit has been claimed from your insurance company, and denied. The *SABS* deal only with injuries arising out of motor vehicle accidents that occurred on or after June 22, 1990.

We do not handle disputes between two or more insurers over which insurer is responsible for the payment of statutory accident benefits. These disputes must be referred to private arbitration under the *Arbitration Act, 1991*. See **Practice Note 10** "Process for Settling Disputes Between Auto Insurance Companies", under **Section C** of the **Code**.

How do I start the dispute resolution process?

The first step is **mediation**. You must send a completed ***Application for Mediation* (FORM A)** to the Dispute Resolution Group. (See **Part 2** of the **Rules – Mediation.**)

MEDIATION

What is mediation?

Mediation is an informal process in which a neutral third party (the mediator) helps the parties resolve the issues in dispute. Mediators work with the parties to find acceptable solutions. They help clarify the issues and explore options that can lead to a satisfactory outcome. Mediators don't take sides and they don't have the power to impose decisions. Our statistics indicate that most disputes are settled at mediation.

How much will it cost?

There is no cost to the insured person for mediation. However, you must pay for your own expenses, such as lawyer's fees, travelling expenses, accounting services, and additional medical reports.

In what languages are mediation services provided?

Mediation services are available in both English and French. French language services are provided at the request of the applicant. Interpretation services in other languages must be arranged by the party requiring them. The party arranging the service must pay the cost.

Do I need a lawyer?

Although a lawyer is not required in mediation, many people feel more comfortable having a lawyer help them with the process.

Should I be there?

Yes. Mediation can be conducted either in person or on the telephone (usually by conference call). You have a responsibility to personally participate in the mediation process, even if you have a representative. If for some extraordinary reason you cannot participate, your representative must have full authority to enter into an agreement or settlement at mediation on your behalf. If your representative does not have this authority, your mediation may be delayed.

How long will it take?

The *Insurance Act* states that all mediations must be concluded within **60 days**. In some cases this limit can be extended on written consent of all the parties.

What documents will I need?

You should try to provide copies of the best available documentation about your case. For medical disputes, this can include such things as doctor's reports, hospital reports, and physiotherapy reports. If your dispute is about the amount of your income, such things as tax returns, financial statements and bank records can be helpful. See **Practice Note 4** "Exchange of Documents" under **Section C** of the **Code**.

Each party may ask the other for relevant documentation. If you fail to produce requested documents that the mediator considers necessary for settlement discussions, this will be noted in the mediator's report.

What if my dispute is not resolved in mediation?

If some issues remain unresolved at the end of the mediation, you have a number of choices. You may continue to negotiate with your insurance company directly. Alternatively, you can opt for arbitration at the Commission, private arbitration, neutral evaluation or court action.

What is a Designated Assessment Centre?

Designated Assessment Centres, or *DAC*s, are health care service providers or facilities appointed under the authority of the *SABS* to provide independent assessments of persons injured in automobile accidents in Ontario. *DAC*s provide a mechanism to assist in the early resolution of disputes between claimants and insurance companies through the provision of neutral, objective, expert opinions on medical issues. You may be required to attend a *DAC* if your accident occurred on or after January 1, 1994. If you fail to attend without reasonable excuse, you may not be permitted to go to mediation or arbitration. See **Practice Note 1** "Using Medical Evidence To Support Your Claim for Accident Benefits" under **Section C** of the **Code**. See also **Practice Note 12** "What Claimants Need to Know about Designated Assessment Centres" under **Section C** of the **Code**. Additional information about DACs and the guidelines they must follow can be found on FSCO's website at **www.fsco.gov.on.ca**

NEUTRAL EVALUATION

What is neutral evaluation?

Neutral evaluation is a process where a neutral third party (the neutral evaluator) provides the parties with an assessment of the issues in dispute, as well as an opinion on the likely results if the dispute were to proceed to arbitration at the Commission or to court. This assessment is intended to help the parties settle their dispute at an early stage.

How do I obtain neutral evaluation?

Neutral evaluation is offered either privately or as part of the arbitration process at the Commission. You and your insurer may agree to refer your dispute to a private (non-Commission) neutral evaluator. The mediator may also make a referral to private neutral evaluation. See **Practice Note 5** "Mediator Referral to Private Neutral Evaluation" under **Section C** of the **Code**. Upon the written request of the parties, the Director of Arbitrations will appoint a person selected by the parties to conduct a private neutral evaluation.

If you want neutral evaluation at the Commission, you must file for arbitration and both parties must agree to neutral evaluation. See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" under **Section C** of the **Code**.

How much will it cost?

Private evaluators set their own rates. The Commission is not responsible for the costs of private neutral evaluation and the terms of payment and cost must be negotiated between the parties and the selected evaluator.

Although there is no additional charge to the insured person for neutral evaluation conducted at the Commission, the insured person must pay the **$100** filing fee for arbitration.

What if my dispute is not resolved through neutral evaluation?

If you participated in private neutral evaluation, and the **Report of the Neutral Evaluator** has been issued, you may choose arbitration at the Commission, private arbitration under the *Arbitration Act*, or court. If you completed neutral evaluation at the Commission, and all the issues did not settle, your file will normally be fast-tracked directly to an arbitration hearing, without the necessity of a pre-hearing discussion.

Arbitration at the Commission's Dispute Resolution Group

What is arbitration?

Arbitration is a decision making process, similar to court. The advantages of arbitration over the court process are that it is quicker, less expensive and less formal. The arbitrator will listen to the witnesses called by each side, review all the evidence filed at the hearing and make an order that is binding on both sides.

Who can apply for arbitration?

Only the insured person may apply for arbitration; the insurance company does not have this right. You may not apply for arbitration unless you have first gone to mediation with your dispute.

How do I apply for arbitration?

You must complete an ***Application for Arbitration*** **(FORM C)** and send it to the Dispute Resolution Group, together with your **$100** filing fee.

How much will it cost?

Over and above the **$100** filing fee, you will also be responsible for your own expenses, such as witness fees, travelling and legal expenses, accounting services, additional medical reports and experts' fees. An arbitrator may award the expenses of a proceeding to either the insured person or the insurer. In awarding expenses to either party, the arbitrator will consider the factors described in **Rules 75 and 76** and under the **Expense Regulation** found in **Section F** of the **Code**.

In some cases the insured person may recover some or all of the expenses of the arbitration from the insurer, if the arbitrator so orders. Expenses awarded by the arbitrator are recoverable only up to the maximums set out in this **Code** under **Rule 78** and under **Section F** Schedule to the Expense Regulation. Legal fees are only recoverable at the rates set out in this **Code** under **Rule 78**. If your lawyer or agent charges more than these rates, you will be responsible to pay your lawyer directly for any additional amount.

In certain cases, the arbitrator may award the insurance company a portion of its expenses which the insured person will be responsible for paying. See **Rule 75** and the **Expense Regulation** found in **Section F** of the **Code**.

As well, if the arbitrator concludes that your claim was frivolous, fraudulent, vexatious or an abuse of process you may be ordered to pay an additional amount up to the amount of the assessment the insurance company has paid. See **Fees and Assessments** found in **Section D** of the **Code**.

In what languages are arbitration services provided?

Arbitration hearings may be held in English or French. French language services are provided at the request of the applicant. Interpretation services in other languages may also be provided by the Dispute Resolution Group, as requested by the applicant and required by the arbitrator. The Dispute Resolution Group will pay the cost of interpretation services required at the hearing.

Do I need a lawyer?

A lawyer is not required for arbitration, but many people are represented. Insurance companies are nearly always represented by lawyers at arbitration. You are encouraged to at least consult a lawyer.

What documents are required?

As in mediation, you should have independent documentation about your claim. You and the insurance company should have already exchanged the relevant documents prior to attending a pre-hearing conference. These documents must ultimately be provided to the arbitrator at the pre-hearing and hearing. If necessary, an arbitrator at the pre-hearing may order the production of other important documents. It is in the best interests of both parties to comply with an order for production in a timely manner. See **Practice Note 4** "Exchange of Documents", under **Section C** of the **Code**.

Should I be present at the arbitration hearing?

Yes. Arbitration hearings are usually held in person at the Commission's offices in North York or at locations throughout Ontario. Sometimes the parties can agree to waive an oral hearing and the arbitrator's decision will be based on the documents and written submissions filed.

How long will the arbitration hearing take?

The length of the arbitration process will vary depending on the nature and complexity of the case. The average length of an oral hearing at the Dispute Resolution Group is between two and three days.

Appeal, Variation/Revocation

What should I do if I think the arbitrator's decision is wrong?

If you think that an arbitrator's decision is wrong, two possible procedures are available. First, you can **appeal** the decision, but only where the arbitrator made an error of law. You will not be allowed to appeal simply because you think the arbitrator should have accepted your evidence instead of the other party's.

A ***Notice of Appeal*** **(FORM I)** must be filed within **30 days** of the date of the arbitration decision. The filing fee is **$250**. Appeals are decided by the Director of Arbitrations or a delegate (Director's Delegate).

The second option is an ***Application for Variation/Revocation*** **(FORM L)**. This process is appropriate where the insured person's situation has changed since the arbitration hearing, where new evidence has become available that was not available for the arbitration hearing, or where there is some clear error in the arbitration decision. The filing fee for an ***Application for Variation/Revocation*** is **$250**.

How do I find a lawyer?

The Law Society of Upper Canada offers a lawyer referral service. For more information, phone (416) 947-3330, and check the Law Society's website at: **www.lsuc.on.ca**, and choose option "Public Legal Information".

User Advisory Groups to the Dispute Resolution Group

The Dispute Resolution Group is fortunate to have two user advisory groups who meet with members of the Dispute Resolution Group's senior management at regularly scheduled meetings throughout the year. The Bar-Dispute Resolution Group Forum ("Counsel Forum") is comprised of lawyers and other representatives who regularly appear on behalf of claimants or insurers within the dispute resolution system. The other group, Companies Forum, is comprised of ADR representatives and claims people from most of the major automobile insurers in Ontario. The members of Companies Forum regularly handle disputed accident benefit claims within our system.

These user groups meet regularly and provide valuable insight and suggestions to the Dispute Resolution Group to ensure that it continues to provide just, flexible, cost effective and efficient dispute resolution services. Further information concerning meeting dates and the minutes of these two advisory groups is available through the FSCO website at **www.fsco.gov.on.ca**.

GENERAL INFORMATION CONCERNING THE TIME LINES FOR THE SERVICES OF THE DISPUTE RESOLUTION GROUP

1. An insured person or an insurer may apply for mediation of a dispute about an insured person's entitlement to accident benefits where a claim has been denied by the insurer or the time period for the insurer to respond to the claim has elapsed **(Rule 12.1)**.

2. An ***Application for Mediation*** in **FORM A** must be filed with the Dispute Resolution Group no later than **2 years** from the date the insurer provided written notice of a refusal to pay the amount claimed **(Rule 11)**.

3. An ***Application for Mediation*** in **FORM A**, completed in accordance with the requirements of **Rule 12.2**, will be registered and assigned to a mediator within 3 weeks of its receipt.

4. Mediation will be concluded within **60 days** of the registration of the completed ***Application for Mediation*** **(Rule 19)**.

5. A **Report of Mediator (Rule 22)** will be issued within **7 business days** of the conclusion of mediation.

6. An ***Application for Arbitration*** in **FORM C** must be filed with the Dispute Resolution Group no later than **2 years** from the date the insurer provided written notice of a refusal to pay an amount claimed. However, an insured person may file a completed ***Application for Arbitration*** within **90 days** after the mediator reports to the parties in the **Report of Mediator (Rule 11)**.

7. An ***Application for Arbitration*** in **FORM C** will be registered and assigned to an arbitration case administrator within **5 business days** of receipt of an ***Application*** completed in accordance with **Rule 25.1**.

8. Dates for holding an arbitration pre-hearing discussion **(Rule 33)** will be available to the parties within **6 to 8 weeks** from the registration of a completed ***Application for Arbitration***.

9. Dates for holding an oral arbitration hearing will be available to the parties within **4 to 6 months** from the conclusion of the pre-hearing discussion.

10. An oral arbitration hearing is generally concluded within **3 days**.

11. An arbitration order from an oral hearing will be issued within **60 to 85 days** from the conclusion of the oral hearing.

12. A written arbitration hearing is generally concluded within a **60 day** period **(Rule 38)**.

13. An arbitration order from a written hearing will be issued on the later of:

    (a) **60 days** after the last day on which the insured person is entitled to file a ***Reply by the Applicant for Arbitration***;

    (b) **30 days** after the last day on which the parties are required to file additional materials or written submissions **(Rule 38)**.

14. A ***Notice of Appeal*** in **FORM I** on a question of law, must be filed within **30 days** of the date of the arbitration order being appealed **(Rule 52)**.

15. A decision in the appeal will be issued within **60 to 85 days** from the conclusion of the oral or written appeal hearing.

16. A request for an **Assessment of Expenses** must be made within **30 days** from the date the order of the arbitrator was issued **(Rule 79)**.

17. An order on an **Assessment of Expenses** will be issued within **60 to 85 days** from the conclusion of the oral or written hearing on expenses.

HOW DO I GET MORE INFORMATION?

More detailed information is available through the Dispute Resolution Group's recorded telephone information service at (416) 250-6714 or toll free at 1-800-517-2332 or FSCO's website at **www.fsco.gov.on.ca**

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PART 1 – GENERAL RULES FOR DISPUTE RESOLUTION

1. INTERPRETATION

1.1 These Rules will be broadly interpreted to produce the most just, quickest and least expensive resolution of the dispute.

1.2 Where something is not specifically provided for in these Rules, the practice may be decided by referring to similar Rules in this **Code**.

1.3 A defect in form or other technical breach will not make a proceeding invalid.

1.4 These Rules are made by the Director under the authority of section 21 of the *Insurance Act* and section 25.1 of the *Statutory Powers Procedure Act*.

1.5 Subject to the requirements of the *Insurance Act* and the *Statutory Powers Procedure Act*, the Director may make changes to these Rules at any time, if he or she considers it appropriate.

1.6 (a) These Rules apply effective May 31, 2001, to all applications for dispute resolution, whenever commenced.

(b) Despite Rule 1.6(a), these Rules do not apply to an arbitration proceeding in which a pre-hearing was held prior to May 31, 2001, unless the parties agree or an arbitrator orders that they apply.

2. GUIDELINES

2.1 The Superintendent of Financial Services, and previously the Commissioner of Insurance, may publish guidelines on the interpretation and operation of the *Statutory Accident Benefits Schedule*. Guidelines are found in **Section B** of the **Code**.

2.2 These guidelines shall be considered when interpreting the *Statutory Accident Benefits Schedule*.

3. PRACTICE NOTES

3.1 The Dispute Resolution Group may issue Practice Notes about policies and administrative procedures. Practice Notes are found in **Section C** of the **Code**.

3.2 Practice Notes are designed to guide users in the dispute resolution process at the Commission. However, they are not binding and do not affect the duty of the adjudicator to make decisions based on the circumstances and merits of each case.

4. DEFINITIONS

4.1 In these Rules:

"accident benefits" means benefits under the *Statutory Accident Benefits Schedule*;

"adjudicator" means the Director or person appointed by the Director under the *Insurance Act* and these Rules to conduct a proceeding requiring the exercise of a statutory power of decision;

"appeal" means an appeal in accordance with section 283 of the *Insurance Act*;

"arbitration" means an arbitration in accordance with section 282 of the *Insurance Act*;

"arbitrator" means an arbitrator appointed by the Director under section 282 of the *Insurance Act*;

"Commission" means the Financial Services Commission of Ontario;

"Director" means the Director of Arbitrations appointed under section 6 of the *Insurance Act* or an employee of the Commission to whom the Director has delegated his or her powers or duties;

"Dispute Resolution Group" means the Dispute Resolution Group of the Commission;

"document" includes written documents, forms, reports, charts, films, photographs, transcripts, videotapes, audio tapes, business and computer files;

"electronic hearing" means a hearing held by conference telephone, or some other form of electronic technology allowing persons to hear one another;

"to file" means to file with the Dispute Resolution Group;

"hearing" means the opportunity to state one's case before an adjudicator in the context of an oral, written or electronic hearing;

"mediation meeting" means a scheduled meeting at which the parties and their representatives attend before a mediator in person, by telephone conference or other forms of electronic technology allowing persons to hear one another;

"mediator" means a mediator appointed by the Director under section 280 of the *Insurance Act*;

"neutral evaluation" means an evaluation under section 280.1 of the *Insurance Act* of the probable outcome of a proceeding in court or arbitration;

"neutral evaluator" means a person appointed by the Director under section 280.1 of the *Insurance Act*;

"oral hearing" means a hearing at which the parties attend in person before an adjudicator;

"private arbitration" means an arbitration under the *Arbitration Act, 1991*;

"private neutral evaluator" means a person who has been appointed by the Director under section 280.1 of the *Insurance Act* to perform a neutral evaluation of the probable outcome of a dispute, other than a person appointed to perform the evaluation at the Dispute Resolution Group under **Rule 44** of the **Code**;

"proceeding" means a matter requiring the exercise of a statutory power of decision;

"Registrar" means the Office of the Registrar of the Dispute Resolution Group;

"serve" means the delivery of a document to a person as permitted by these Rules;

"Statutory Accident Benefits Schedule" means any of the following:

(a) the *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996* for accidents that occur after October 31, 1996; or

(b) the *Statutory Accident Benefits Schedule - Accidents after December 31, 1993* and Before November 1, 1996 for accidents that happened on or between January 1, 1994 and October 31, 1996 inclusive; or

(c) the *Statutory Accident Benefits Schedule - Accidents Before January 1, 1994* for accidents that happened on or between June 22, 1990 and December 31, 1993 inclusive.

"written hearing" means a hearing held by means of the exchange and filing of documents, whether in written form or by electronic means.

5. DISPUTE RESOLUTION SERVICES AND DOCUMENTS

5.1 A person has the right to communicate in French, and to receive available services in French from the Dispute Resolution Group as provided in the *French Language Services Act*.

5.2 French language services in mediation, arbitration, neutral evaluation, variation/revocation and appeal are provided at the request of the insured person.

5.3 In mediation, interpretation services in languages other than French and English must be arranged by the party requiring them. The party arranging the interpretation service must pay the cost.

5.4 In arbitration, variation/revocation and appeal hearings, interpretation services in languages other than French and English will be arranged by the Dispute Resolution Group where requested by the insured person and required by the adjudicator. The Dispute Resolution Group will pay the cost of interpretation services required at the hearing.

5.5 Where interpretation services are provided at a hearing, an interpreter must make an oath or affirm that he or she will truly and faithfully translate the evidence.

5.6 The Dispute Resolution Group may issue letters of direction, notices and other documents signed by the Director.

5.7 Where these Rules require the delivery of a document by the Dispute Resolution Group, delivery will be deemed to have occurred where:

(a) one of the methods of delivery permitted under **Rule 7** is used; and

(b) the document is sent to the last known address of the party, contained in the records of the Dispute Resolution Group.

6. FILING

6.1 Where these Rules require a document to be filed:

(a) the document must be delivered to the Dispute Resolution Group;

(b) one of the methods of delivery permitted under **Rule** 7 must be used; an

(c) the time frames set out in **Rule** 7 apply.

7. SERVICE OF DOCUMENTS

7.1 A document must be served by one of the following methods:

(a) personal delivery;

(b) regular, registered, or certified mail;

(c) courier service, including Priority Courier;

(d) facsimile;

(e) document exchange on a person who participates in an exchange service;

(f) electronic transmission; or

(g) any other manner specified by the Director.

7.2 A document that is served by facsimile or electronic transmission must include a cover page indicating:

(a) the name, address, telephone number and electronic transmission address (if any) of the sender;

(b) the name of the individual to be served;

(c) the date and time the document is being sent;

(d) the total number of pages being sent including the cover page; and

(e) the name and telephone number and electronic transmission address (if any) of a person to contact in the event of a problem.

7.3 Service by a party or delivery by the Dispute Resolution Group will be considered to take place within the time frames set out below:

(a) if a document is served by personal delivery, service takes place on the day delivery is made;

(b) if a document is served by regular, registered, or certified mail, service takes place on the fifth day after the date the post office stamps the mailed document;

(c) if a document is served by courier service, including Priority Courier, service takes place on the earlier of receipt, or on the second day after the document is given to the courier;

(d) if a document is served by facsimile or electronic transmission, service takes place on the day that the document is sent;

(e) if the document is served by means of a document exchange on a person who participates in an exchange service, service takes place one day after the deposit, if the document is date-stamped in the presence of the person depositing the document;

(f) if a document is served by any other means specified by the Director, service takes place within the time specified by the Director.

8. CALCULATION OF TIME

8.1 To calculate time under these Rules or an order:

(a) where there is a reference to a number of days between two events, they will be counted by excluding the day on which the first event happens and including the day on which the second event happens;

(b) where the time for doing an act under these Rules ends on a Saturday, Sunday, or a statutory holiday, the act may be done on the next day that is not a Saturday, Sunday, or a statutory holiday; and

(c) filing or service of a document **after 4:45 p.m.** or on a Saturday, Sunday or a statutory holiday will be considered to be made on the next day that is not a Saturday, Sunday, or a statutory holiday.

9. REPRESENTATION

9.1 A party may represent him or herself or may appoint another person to represent him or herself.

(a) A party must provide the Dispute Resolution Group with his or her own name, address, telephone number and electronic transmission address (if any), and if represented, the name, address, telephone number and electronic transmission address (if any) of their representative;

(b) Parties and their representatives must provide the Dispute Resolution Group with written notice of any change of their address, telephone number and electronic transmission address (if any). The Dispute Resolution Group is entitled to rely upon the last known address, telephone number and electronic transmission address (if any) contained in its records.

9.2 Subject to **subsection 9.3**, a party who appoints a representative must provide full authorization to the representative to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute. The Dispute Resolution Group may request written confirmation from the party that a representative has this authority.

9.3 Where an insurer's representative has limited authority to enter into an agreement or settlement, an officer of the company with the requisite authority must attend or be available by telephone for the duration of the mediation, settlement discussion or other proceeding.

9.4 The Registrar or a mediator, neutral evaluator or adjudicator, as the case may be, may adjourn a mediation, neutral evaluation or proceeding, on such terms as he or she considers just, if a party is not present and their representative does not have the requisite authority outlined in subsections 9.2 and 9.3.

9.5 A party who changes his or her representative must promptly notify the former representative, the other parties and the Dispute Resolution Group, in writing, of the name, address, telephone number and electronic transmission address (if any) of the new representative. The new representative must also confirm his or her appointment in writing. The Dispute Resolution Group is entitled to rely on the last written notification concerning a party's representative contained in its files.

9.6 A party who is represented and wishes to act on his or her own behalf, must notify the representative, the other parties and the Dispute Resolution Group, in writing, of the decision to act on his or her own behalf.

9.7 A representative who seeks to withdraw from a proceeding must:

(a) provide a written request for withdrawal, with reasons, to the Dispute Resolution Group and all parties to the proceeding;

(b) provide the last known address, telephone number and electronic transmission address (if any) of the represented party.

9.8 Where the party represented provides written consent to the representative's request for withdrawal, the Registrar or an adjudicator shall permit the representative's withdrawal. Otherwise, an adjudicator may permit the representative to withdraw, subject to such terms as the adjudicator considers just.

9.9 An adjudicator may exclude from a proceeding hearing anyone, other than a duly qualified barrister and solicitor, appearing as a representative or agent on behalf of a party, or as an advisor to a witness, if the adjudicator finds that such person is not competent to properly represent or to advise the party or witness or does not understand and comply with these Rules and the duties and responsibilities of a representative, agent or advisor.

10. PARTY UNDER DISABILITY

10.1 Subject to **Rule 10.2**, a party to a mediation, settlement discussion, neutral evaluation or proceeding is presumed to have the mental capacity to manage his or her property, appoint and instruct a representative, and conduct his or her own case.

10.2 A minor, or a person who has been declared mentally incapable, within the meaning of **Sections 6 or 45** of the *Substitute Decisions Act, 1992, (SDA)* must commence a mediation or other proceeding through:

(a) the Public Guardian and Trustee or a Court appointed guardian of property under the provisions of the *SDA*; or

(b) an attorney under a valid continuing power of attorney that gives the attorney authority over all the property of the party; or

(c) in the case of a minor,

(i) a parent with whom the minor resides;

(ii) a person with lawful custody of the minor;

(iii) a court appointed guardian of the minor's property under the provisions of the *Children's Law Reform Act*; or,

(iv) the Children's Lawyer, in the event there is no person available under subparagraphs (i), (ii), (iii) or if there is a conflict of interest between the minor and such person.

10.3 Where an adult party has not been declared mentally incapable under the provisions of the *SDA*, but exhibits signs of mental difficulty during the course of a mediation, settlement discussion, neutral evaluation or proceeding, either party may request a hearing on a preliminary issue, or the adjudicator or the Registrar may direct a hearing on a preliminary issue to determine whether:

(a) the party has the mental capacity to proceed in the dispute resolution process;

(b) there is an attorney with a valid continuing power of attorney over the party's property; or

(c) there is a person such as a spouse, same sex partner, near relative, close friend or a professional such as a doctor, lawyer or business entity, such as a trust company, who has made or intends to make arrangements for the appointment of a guardian over the party's property under the provisions of the *SDA*.

10.4 Parties shall be given written notice of the hearing on a preliminary issue to inquire into a party's mental capacity to proceed in the dispute resolution process.

10.5 Where an adjudicator is not satisfied that a party has the mental capacity to proceed in the dispute resolution process, and there is no attorney or person such as described in **Rule 10.3(b) and (c)**, the adjudicator may appoint a spouse, same sex partner or near relative of the party to act on the party's behalf if that person, in the adjudicator's opinion, is suitable, willing and able to proceed in the dispute resolution process and to receive and administer statutory accident benefits on behalf of the party who has exhibited signs of mental difficulty. The adjudicator may place such conditions or restrictions upon appointments pursuant to this section, as the adjudicator considers reasonable and necessary to protect the interests of the person exhibiting mental difficulty, the other parties to the proceeding and the dispute resolution process.

10.6 Where there is no person such as described in **Rules 10.2, 10.3 or 10.5** available to act, the adjudicator may notify the Public Guardian and Trustee to request that appropriate steps be taken pursuant to the provisions of the *SDA*.

10.7 The representative of a person under a disability under **Rule 10.2** or the representative of a party who has been found to lack the mental capacity to proceed in the dispute resolution process under **Rule 10.5**, shall comply with the approval of settlement requirements of Rule 7.08 of the *Rules of Civil Procedure*.

11. TIME LIMITS FOR MEDIATION, NEUTRAL EVALUATION OR ARBITRATION

11.1 An application for mediation, neutral evaluation or arbitration must be filed no later than **2 years** from the date the insurer provided written notice of a refusal to pay the amount claimed.

11.2 Despite **Rule 11.1**, an insured person may file a completed ***Application for Arbitration*** within **90 days** after the mediator reports to the parties in the **Report of Mediator** or within **30 days** after the neutral evaluator, appointed by the Director, reports to the parties in the **Report of Neutral Evaluator**, whichever is later.

11.3 The limitation period is not extended by the issuance of an amendment to a **Report of Mediator** under **Rule 23.**

12. APPLICATION FOR MEDIATION

12.1 An insured person or an insurer may apply for mediation of any dispute about an insured person's entitlement to accident benefits or the amount of those benefits where a claim has been denied or the prescribed time period for the insurer to respond to the claim has elapsed.

12.2 A party who applies for mediation must file, in duplicate, a completed ***Application for Mediation*** in **FORM A**, which includes:

(a) a description of each issue in dispute;

(b) a list of available documents to which the applicant intends to refer in the mediation;

(c) a list of existing documents that the applicant wishes to obtain from other sources, including the other party, which are required for the purpose of discussing settlement of the dispute; and

(d) if the applicant is the insurer, the name, address, telephone, facsimile number and electronic transmission address (if any) of its company representative.

If available, the applicant should file a copy of the insurer's written explanation of denial or the **Explanation of Benefits Payable by Insurance Company** form.

> For additional guidance on the exchange of documents between the parties, see **Practice Note 4** found in **Section C** of the **Code**.

12.3 If it appears that an ***Application for Mediation*** is incomplete, has been received after the time required for commencing the proceeding has elapsed, exceeds the jurisdiction of the dispute resolution process under the *Act* and its Regulations, or is frivolous, vexatious or an abuse of process, the Dispute Resolution Group will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the applicant and his or her representative; and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

12.4 Where the applicant does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 12.3(b)**, the Dispute Resolution Group may reject the ***Application.***

12.5 A party may not reapply for mediation of any dispute that has been previously mediated.

13. APPOINTMENT OF A MEDIATOR

13.1 On receipt of a completed ***Application for Mediation***:

(a) the Dispute Resolution Group will deliver a copy of the completed ***Application*** and a ***Response to the Application for Mediation*** in **FORM B** to the other party; and

(b) a mediator will be appointed promptly.

14. RESPONSE TO APPLICATION FOR MEDIATION

14.1 The party responding to the ***Application for Mediation*** must, within **10 days** of receiving the ***Application***, file a completed ***Response to an Application for Mediation*** in **FORM B**, which must include:

(a) a response to each issue raised in the ***Application***;

(b) details of any additional issues which are to be mediated;

(c) If the respondent is the insurer, a copy of the insurer's written explanation of denial or **Explanation of Benefits Payable by Insurance Company** form if it was not included in the ***Application***;

(d) a list of available documents to which the responding party intends to refer in the mediation;

(e) a list of existing documents that the responding party wishes to obtain from other sources, including the other party, which are required for the purpose of discussing settlement of the dispute; and

(f) if the responding party is represented, the name, address, telephone number, facsimile number and electronic transmission address (if any) of the representative.

14.2 The Dispute Resolution Group may reject an incomplete ***Response*** which may result in delay or a failed mediation.

14.3 The responding party must deliver the completed ***Response*** to every other party in the dispute.

15. COMBINING APPLICATIONS AND ADDING NEW ISSUES

15.1 Where two or more ***Applications for Mediation*** have been filed involving the same parties or the same accident, the Dispute Resolution Group may:

(a) combine the ***Applications***;

(b) schedule any mediation meetings to take place one immediately after the other; or

(c) on the consent of all parties, conduct any mediation meetings with all parties present.

15.2 Where either party wishes to add an additional issue to a mediation, they must provide a written request identifying the new issue to the mediator and the other party at least **10 days** prior to the scheduled date of the mediation meeting. Thereafter, issues may be added on the consent of all parties.

16. THE MEDIATION PROCESS

16.1 Mediation may be conducted in person, by telephone, or by any other means that the mediator considers appropriate.

16.2 At least **10 days** before the scheduled mediation meeting, the parties shall exchange with the other parties and provide the appointed mediator with the key documents required to discuss the settlement of any issue in dispute.

> See **Practice Note 4** "Exchange of Documents" found in **Section C** of the **Code**.

16.3 The mediator will look into all the issues in dispute which are identified on the ***Application for Mediation*** or the ***Response to an Application for Mediation*** or by written request under **Rule 15.2** and will help the parties settle as many of the issues as possible.

17. PARTICIPATION IN MEDIATION

17.1 Parties to the mediation and their representatives (if any) must participate in good faith in the mediation process and provide all relevant documents within the time frames set out in these Rules.

17.2 The appointment of a representative does not relieve any party of the obligation to participate in the mediation, in person, by telephone or other electronic technologies, and to provide instructions to any representative in respect of any issue in dispute or settlement offers made.

17.3 Where a party does not comply with **Rules 17.1** and **17.2** the mediator may:

a) adjourn the mediation on such terms as he or she considers appropriate; or

b) report to the parties that mediation did not take place.

18. CONFIDENTIALITY DURING MEDIATION

18.1 All statements and offers to settle made during mediation, except those contained in the **Report of Mediator**, are made for the purpose of settlement and shall not prejudice any position that the parties take in any subsequent arbitration or court proceeding.

18.2 A mediator shall not be required to testify or produce his or her notes or other documents in a civil proceeding or in a proceeding before any board or tribunal respecting a mediation or respecting information obtained in the discharge of the mediator's duties under these Rules.

18.3 Where a party to a mediation provides information to the mediator in confidence, the mediator will not disclose the information without the permission of the party, unless required by law to do so.

18.4 If a party provides documents to a mediator in confidence, the mediator will return the documents to the party and the documents will not form part of the mediation file.

18.5 The Dispute Resolution Group will not provide any part of the mediation file to a neutral evaluator or adjudicator, except the **Report of Mediator**.

19. TIME LIMITS FOR MEDIATION

19.1 Subject to **Rule 19.2**, mediation must be concluded within **60 days** of the filing of an ***Application for Mediation***, completed in accordance with the requirements of **Rule 12.**

19.2 Subject to **Rule 21.1(a)** the parties may agree to extend the **60 day** time limit for mediation.

19.3 Where the parties have agreed to extend the time limit, they must:

(a) consult with the mediator; and

(b) provide the mediator with written confirmation of the dates agreed upon for the extension.

20. SETTLEMENT OF AN ISSUE

20.1 Where the parties settle an issue on their own during the mediation process, they will advise the mediator of the terms of their settlement.

20.2 A settlement is subject to legal requirements, as applicable, including those governing final settlements.

See the **Settlement Regulation** found in **Section E** of the **Code**.

21. FAILURE OF MEDIATION

21.1 Mediation has failed on an issue when:

(a) the mediator is of the opinion that mediation will fail and notifies the parties; or

(b) the time limit for mediation, including any extension, has expired and no settlement has been reached.

21.2 If mediation fails on any of the issues in dispute, the insurer will provide the mediator with its last offer in respect of such issue or issues.

21.3 No party may bring a proceeding in any court, refer the issues in dispute to an arbitrator, or agree to submit an issue to private arbitration unless mediation was sought and has failed.

22. REPORT OF MEDIATOR

22.1 The mediator will record the following in the **Report of Mediator**:

(a) the mediator's description of the issues that were in dispute;

(b) if any of the issues were resolved, the terms of any settlement;

(c) the insurer's last offer in respect of any issue that remains in dispute;

(d) any steps the parties agree to take to help them settle any issue that remains in dispute;

(e) a list of documents requested by the parties that have not been produced and that, in the opinion of the mediator, were required for the purpose of discussing settlement of any issue that remains in dispute; and

(f) the mediator's recommendation whether issues that remain in dispute should be referred to neutral evaluation.

22.2 The Dispute Resolution Group will deliver a copy of the **Report of Mediator** to the parties, to a person appointed by the Director to perform a neutral evaluation, and to an arbitrator appointed by the Director.

23. AMENDMENT OF MEDIATOR'S REPORT

23.1 If a party believes that the **Report of Mediator** is not accurate, the party must notify the mediator and the other parties in writing, with reasons, within **10 days** of receiving the **Report**.

23.2 After considering the reasons and the comments of the parties, the mediator may issue an amendment to the **Report of Mediator**, if the mediator considers it appropriate.

23.3 The Dispute Resolution Group will deliver a copy of the amendment to the **Report of Mediator** to the parties, to the person approved by the Director to perform a neutral evaluation, and to an arbitrator appointed by the Director.

24. REFERRAL TO NEUTRAL EVALUATION

24.1 If mediation fails on any of the issues in dispute, the parties jointly or the mediator who conducted the mediation may, for the purpose of assisting in the resolution of the issues in dispute, refer the issues in dispute to a person appointed by the Director for an evaluation of the probable outcome of a proceeding in court or arbitration.

24.2 Where the mediator or the parties jointly refer the issues in dispute to neutral evaluation, the parties shall either:

(a) jointly retain a private neutral evaluator appointed by the Director; or

> See **Practice Note 5** "Mediator Referral to Private Neutral Evaluation" under **Section C** of the **Code**.

(b) If an ***Application for Arbitration*** in **FORM C** is filed, jointly request neutral evaluation at the Commission in accordance with the Rules under **PART 3, ARBITRATION AND NEUTRAL EVALUATION AT THE COMMISSION.**

> See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission" under **Section C** of the **Code**.

24.3 The Director will promptly appoint a person to conduct a private neutral evaluation under **Rule 24.2(a)** upon receipt in writing of:

(a) the name, address, telephone number and electronic transmission address (if any) of the person who has been jointly retained by the parties;

(b) confirmation from the person jointly retained that he or she has agreed to perform the neutral evaluation at the parties' expense and in accordance with the requirements of the *Insurance Act*; and

(c) confirmation of the applicable mediation file number.

24.4 Where the issues in dispute are referred to neutral evaluation, no party may proceed to court or arbitration unless the report of the person who performed the neutral evaluation has been given to the parties.

PART 3 – ARBITRATION AND NEUTRAL EVALUATION AT THE COMMISSION

25. APPLICATION FOR ARBITRATION

25.1 An insured person applying for arbitration (the "applicant") must file a completed ***Application for Arbitration*** in **FORM C**, which includes:

(a) a description of each issue to be arbitrated, provided the issues were submitted to mediation and failed;

(b) an explanation why any document identified in the **Report of Mediator** as having been requested by the insurer, has not been provided to the insurer;

(c) a list of other key documents in the applicant's possession to which he or she intends to refer in the arbitration;

(d) a list of key documents the applicant intends to obtain from other sources, including those documents the applicant requests from the insurer, such as surveillance evidence;

(e) payment of the application filing fee set out in **Section D** of the **Code**; and

(f) an indication whether the applicant prefers an oral, electronic or written hearing.

25.2 The applicant must also:

(a) file a copy of the **Report of Mediator** related to the issues to be arbitrated; and

(b) where an evaluation by a private neutral evaluator has occurred, file the **Report of the Neutral Evaluator** or confirmation that the parties have received a copy of it.

25.3 The insured person may request neutral evaluation at the Commission in the ***Application for Arbitration***, unless an evaluation by a private neutral evaluator has occurred. Neutral evaluation at the Commission will be conducted according to **Rules 44** and following:

> See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" under **Section C** of the **Code**.

25.4 If it appears that an ***Application for Arbitration*** is incomplete, has been received after the time required for commencing the proceeding has elapsed, exceeds the jurisdiction of the dispute resolution process under the *Insurance Act* and its Regulations, or is frivolous, vexatious or an abuse of process, the Registrar or an arbitrator will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the applicant and his or her representative; and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

25.5 Where the applicant does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 25.4(b)**, the Registrar or an arbitrator may reject the ***Application***.

25.6 The Registrar will deliver a copy of the completed ***Application for Arbitration*** to the other parties.

26. OPTIONS AVAILABLE TO AN INSURER, INCUDING NEUTRAL EVALUATION AT THE COMMISSION

26.1 Within **20 days** of receipt by the insurer of the ***Application for Arbitration***, the insurer must respond in **one** of the following ways:

(a) serve and file a ***Response by Insurer*** in **FORM E**, completed in accordance with **Rule 27**, together with a ***Statement of Service*** in **FORM F**; or

(b) if the insured person has requested neutral evaluation at the Commission, the insurer must file an ***Agreement to Neutral Evaluation***, in **FORM D**, by facsimile transmission; or

(c) unless a private neutral evaluation has occurred, the insurer may request neutral evaluation at the Commission by obtaining the written consent of the applicant, and filing an ***Agreement to Neutral Evaluation*** in **FORM D**, by facsimile transmission.

26.2 Where the parties jointly choose Neutral Evaluation at the Commission, it shall be conducted according to **Rules 44** and following.

27. RESPONSE BY INSURER

27.1 Where parties do not jointly choose neutral evaluation, the ***Response by Insurer*** in **FORM E** must include:

(a) a response to each issue raised in the ***Application for Arbitration***;

(b) a description of any additional issues which the insurer wishes to have arbitrated, provided that the issues were submitted to mediation and failed;

(c) an explanation why any document identified in the **Report of Mediator** as having been requested by the applicant, has not been provided to the applicant;

(d) a list of other key documents in the insurer's possession to which it intends to refer in arbitration, including surveillance evidence;

(e) a list of key documents the insurer intends to obtain from other sources, including those the insurer requests from the applicant; and

(f) an indication whether the insurer prefers an oral, electronic or written hearing.

27.2 If it appears that a ***Response by Insurer*** is incomplete or exceeds the jurisdiction of the dispute resolution process under the *Insurance Act* and its Regulations, the Registrar or an arbitrator will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Response*** to the Insurer and its representative; and

(b) hold the ***Response*** in abeyance for **20 days** from the delivery of the notice.

27.3 Where the Insurer does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 27.2**, the Registrar or an arbitrator may reject the ***Response*** and the arbitration will proceed on an uncontested basis.

28. Appointment of an arbitrator

28.1 Where the Director has not appointed a private neutral evaluator under **Rule 24.3** or a neutral evaluator at the Commission under **Rule 44.1**, the Director will promptly appoint an arbitrator. The Director may also appoint an arbitrator to conduct a pre-hearing or other interim proceeding.

29. Reply by the applicant for arbitration

29.1 Within **10 days** of being served with the ***Response by Insurer***, the applicant must reply to any new issues raised by:

(a) serving a ***Reply by the Applicant for Arbitration*** in **FORM G** on the insurer and any other parties; and

(b) filing a copy of the ***Reply*** together with a ***Statement of Service*** in **FORM F**.

29.2 The Reply by the ***Applicant for Arbitration*** is optional where no new issues are raised in the Response by Insurer.

30. Combining applications

30.1 Where two or more ***Applications for Arbitration*** have been filed and it appears that:

(a) they have an issue or question of law, fact, or policy in common; or

(b) the application of this Rule will result in the most just, quickest, and least expensive means to deal with the ***Applications***;

The Registrar or an arbitrator will notify the parties in writing of the intention to:

(c) combine the proceedings;

(d) schedule the proceedings to be heard at the same time;

(e) schedule one or more proceedings to be heard one immediately after the other by the same arbitrator; or

(f) suspend the scheduling of a proceeding or proceedings until the determination of any one of them.

30.2 Where a party objects to a notice made under **Rule 30.1**, the party must promptly notify the Dispute Resolution Group and the other parties involved, in writing, of the objection.

30.3 An arbitrator will consider an objection made under **Rule 30.2** and make an order on such terms as he or she considers just.

31. SEVERING ISSUES

31.1 Where the Registrar or an arbitrator considers it appropriate, or where the parties agree and the arbitrator approves, the Dispute Resolution Group will notify the parties in writing that an ***Application for Arbitration*** in **FORM C** is to be divided into distinct issues to be heard separately.

31.2 If more than one final order is made in an application, each order will stand on its own for the purposes of an appeal or a variation/revocation proceeding.

31.3 Where a party objects to a notice made under **Rule 31.1**, the party must promptly notify the Dispute Resolution Group and the other parties involved, in writing, of the objection.

31.4 An arbitrator will consider the objection and may make an order on such terms as he or she considers just.

32. EXCHANGE OF DOCUMENTS BEFORE PRE-HEARING

32.1 At least 10 days before the pre-hearing discussion, each party must:

(a) exchange all documents identified in the Application for Arbitration and the Response by Insurer, or explain why a document has not been provided;

(b) establish reasonable time frames for the exchange of any remaining documents;

(c) file the key documents the pre-hearing arbitrator will require to understand the issues in dispute;

(d) file a list of outstanding document requests and identify any disputed items.

32.2 Subject to the time lines under **Rule 39**, the parties have an ongoing responsibility to ensure the prompt and complete exchange of documents that are reasonably necessary to determine the issues being arbitrated, including updates to the information previously exchanged and any additional documents obtained.

32.3 Subject to **Rule 39**, an arbitrator may at any time order the production of documents or the giving of information that he or she considers relevant to the determination of the issues in the arbitration, on such terms as he or she considers appropriate.

33. PRE-HEARING DISCUSSION

33.1 One or more pre-hearing discussions may be held before an arbitrator who will attempt to resolve the dispute, and will assist the parties to prepare for the arbitration by:

(a) identifying and obtaining agreement as to the issues for arbitration;

(b) obtaining agreement as to facts;

(c) deciding any disputes relating to the identification and exchange of documents, making orders and setting time lines for the exchange of outstanding documents;

(d) dealing with procedural and preliminary issues, and requests for interim relief or interim expenses;

(e) identifying the expert and lay witnesses to be called at the hearing and determining the length of hearing;

(f) setting dates for the hearing;

(g) arranging the form in which document briefs or a joint book of documents will be submitted to the hearing arbitrator; and

(h) dealing with any other matters that the arbitrator considers appropriate.

33.2 A pre-hearing discussion may be held in person, by telephone conference call, electronically, or by any other means that the pre-hearing arbitrator considers appropriate.

33.3 The Dispute Resolution Group will provide parties with reasonable notice of the date and manner of the pre-hearing discussion.

33.4 The pre-hearing arbitrator will confirm the results of the pre-hearing discussion to the parties in writing.

33.5 An arbitrator who presides at a pre-hearing discussion at which the parties attempt to settle issues will not preside at the hearing unless the parties consent.

34. FAILURE TO COMPLY

34.1 Where a party fails to comply with a time requirement established by these Rules or by order or agreement, or fails to produce documents in compliance with an order or agreement, an arbitrator may:

(a) order a party to pay expenses (including interim expenses), or deny expenses to a party;

(b) exclude a document filed;

(c) impose a new timetable for compliance;

(d) draw an adverse inference against a party; and

(e) make such other order as the arbitrator considers just.

34.2 Either party may make a written request for the resumption of a pre-hearing discussion where a party fails to comply with a time requirement established by these Rules or by order or agreement, or fails to produce documents in compliance with an order or agreement.

34.3 The Dispute Resolution Group will attempt to accommodate a party's written request for a resumption of the pre-hearing discussion where practicable.

35. SETTLEMENT CONFERENCE PRIOR TO SCHEDULED HEARING DATE

35.1 Either party may contact the Registrar to request a settlement conference.

35.2 The party seeking the settlement conference should confirm the consent of all other parties to the settlement conference and provide times and dates for the conference that are acceptable to all parties.

35.3 The Registrar will attempt to accommodate a joint request of the parties for a settlement conference and may assign a mediator or adjudicator to facilitate resolution of the issues in dispute.

35.4 The Registrar or an arbitrator may also initiate a settlement conference, provided the parties consent.

35.5 An arbitrator who facilitates a settlement conference prior to the scheduled hearing shall not preside at the hearing unless the parties consent.

36. CONFIDENTIALITY DURING SETTLEMENT DISCUSSIONS

36.1 No statements made for the purpose of settlement or any offer to settle made during a pre-hearing discussion or settlement conference shall prejudice any position the parties may take in any subsequent proceeding.

36.2 No person appointed to facilitate the settlement of an issue in dispute before the Dispute Resolution Group shall be compelled to give testimony or produce his or her notes or other documents in a proceeding before the Dispute Resolution Group, in a private arbitration or civil proceeding through the courts, with respect to matters that come to his or her knowledge in the course of exercising his or her duties under these Rules, the *Insurance Act*, or its Regulations.

37. HEARINGS

37.1 The arbitrator may:

(a) hold an oral hearing;

(b) hold a written hearing;

(c) hold an electronic hearing; or

(d) hold a hearing which combines one or more of the above formats.

37.2 The arbitrator will not hold a written hearing where a party satisfies the arbitrator that there is a good reason for not doing so.

37.3 The arbitrator will not hold an electronic hearing where a party satisfies the arbitrator that holding an electronic hearing will significantly prejudice the party.

37.4 **Rules 37.2 and 37.3** do not apply if the only purpose of the hearing is to deal with procedural matters.

37.5 The parties to an arbitration shall be given reasonable notice of a hearing, the manner of the hearing and in the case of a written or electronic hearing, a

statement that either party may object to a written or electronic hearing on the grounds set out in **Rules 37.2 and 37.3** (except in the case of a hearing on procedural matters only).

37.6 The arbitrator will determine all issues in dispute and such other issues as the parties may agree, where mediation has taken place.

37.7 Where notice of hearing has been sent to a party and a party does not attend at an oral or electronic hearing, or participate in a written hearing, the arbitrator may proceed with the hearing in the party's absence or without the party's participation, as the case may be, and the party is not entitled to any further notice in the proceeding.

38. TIME LINES FOR WRITTEN HEARINGS

38.1 In a written hearing, the arbitrator:

(a) may, within **30 days** after the last day on which the insured person is entitled to file a ***Reply by the Applicant for Arbitration***, request additional materials or written submissions from the parties on any issue or matter in dispute;

(b) may proceed to determine the issues even though a party has failed to file additional materials or written submissions, if the arbitrator is satisfied that the Dispute Resolution Group has delivered the request for additional materials or submissions;

(c) will make the order based on the materials and submissions filed;

(d) will issue an order on the later of:

(i) **60 days** after the last day on which the insured person is entitled to file a ***Reply;*** and

(ii) **30 days** after the last day on which the parties are required to file additional materials or written submissions.

39. EVIDENCE

39.1 Subject to **Rule 39.2**, all documents, reports (including experts' reports) and assessments to be introduced at a hearing by either party must be served on the other party at least **30 days** before the first day of the hearing.

39.2 In extraordinary circumstances, a party may seek an arbitrator's permission to serve a document, report or assessment on the other party for use at a hearing less than **30 days** before the first day of hearing.

39.3 The hearing arbitrator will determine the relevance, materiality, and admissibility of evidence submitted at the hearing, but will not admit evidence at a hearing that:

(a) would not be admissible in a court by reason of any privilege under the law of evidence; or

(b) is not admissible under the *Insurance Act*; or

(c) was not served on the opposing party in accordance with **Rules 39.1 and 39.2,** unless the hearing arbitrator is satisfied that extraordinary circumstances exist to justify an exception.

40. SURVEILLANCE EVIDENCE

40.1 If a party intends to rely on any portion of surveillance or investigative evidence, including videotapes, photographs, reports, notes and summaries of surveillance observations or investigations, at least 30 days before the hearing, the party shall provide:

(a) the names and qualifications of the persons who secured the investigative or surveillance evidence, the dates, times and places where any surveillance or investigation was undertaken; and

(b) copies of all videotapes, photographs, investigative reports, notes and summaries taken or prepared in connection with the issues in dispute.

41. WITNESSES

41.1 Each party must provide, the other parties with the names of witnesses that the party intends to call and the names of persons the party requires to attend for cross-examination on a report, at least **30 days** before the first day of the hearing.

41.2 Every party must notify a potential witness of the intention to call him or her to give evidence at the hearing at least **30 days** before the first day of the hearing.

41.3 An arbitrator may:

(a) excuse a witness from attending at the hearing, if the witness was not identified at the pre-hearing under **Rule 33**, or notified at least **30 days** before the first day of hearing under **Rule 41.2**; or

(b) make such other order as the arbitrator considers just.

41.4 An arbitrator has the power to summon and enforce the attendance of a witness and require him or her to give evidence on oath or otherwise, and to produce documents, records, and things.

41.5 A party may require the attendance of a witness by serving a ***Summons to Witness*** in **FORM N**, in accordance with **Rule 73**.

> See **Practice Note 8** "Attendance of a Witness to an Arbitration Hearing by Summons" found in **Section C** of the **Code**.

42. EXPERT WITNESSES

42.1 If a party intends to introduce a report by an expert, the full name and qualifications of the expert who prepared the report must accompany the report.

42.2 If a party intends to call an expert witness to present evidence at a hearing, that party must serve and file a document setting out the following:

(a) the full name, address and qualifications of the expert witness;

(b) the subject matter of the testimony to be presented; and

(c) the substance of the facts and opinion which the witness will present.

The time lines and requirements set out under **Rule 39 and Rule 41** apply.

42.3 Where a party does not comply with the requirements of this Rule, an arbitrator may exclude a witness from the hearing or make such other order as the arbitrator considers just.

42.4 No party may call more than two expert witnesses to give opinion evidence at a hearing, unless otherwise ordered by an arbitrator.

43. REOPENING OF HEARING

43.1 The arbitrator may reopen a hearing at any time before he or she makes a final order disposing of the arbitration.

43.2 **Rules 37 to 42** apply to the reopening as modified by the arbitrator.

44. NEUTRAL EVALUATION AT THE COMMISSION

44.1 Upon receipt of a completed ***Agreement to Neutral Evaluation at the Commission*** in **FORM D** and confirmation of the consent of the parties, the Director will:

(a) suspend the appointment of an arbitrator;

(b) promptly appoint a person to perform the neutral evaluation; and

(c) confirm the appointment with the parties.

44.2 Within **30 days** of notice of the appointment of a neutral evaluator from the Director (see **Rule 44.1**), the parties must file a ***Joint Statement for Neutral Evaluation at the Commission*** in **FORM H** containing:

(a) a description of the legal and factual issues to be evaluated;

(b) confirmation that all documents listed in the **Report of Mediator** and all other documents necessary for an evaluation of the issues have been exchanged by the parties; and

(c) two proposed half-day dates for the neutral evaluation which are no later than **60 days** after the date of the appointment of the neutral evaluator.

44.3 If it appears that the ***Joint Statement for Neutral Evaluation at the Commission*** has not been completed in accordance with all requirements of **Rule 44.2** or the dispute is otherwise unsuitable for neutral evaluation, the Director will:

(a) deliver written notice of the deficiencies or concerns identified;

(b) hold the neutral evaluation in abeyance for **10 days** from the delivery of the notice.

44.4 Where a party does not address the deficiencies or concerns within the **10 days** provided under **Rule 44.3(b)**, the Director may terminate the neutral evaluation and promptly appoint an arbitrator.

44.5 In deciding whether a case is suitable for neutral evaluation, the Director shall have regard to the considerations set out in **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" found in **Section C** of the **Code**.

44.6 Upon receipt of the parties' completed ***Joint Statement***, the Director shall promptly select one of the dates for the neutral evaluation and shall notify the parties of the date, time, and location of the neutral evaluation.

45. CASE SUMMARY FOR NEUTRAL EVALUATION

45.1 At least **10 days** prior to the date of the neutral evaluation, each party must exchange and file a **case summary** containing:

(a) a summary of their submissions on the issues to be evaluated; and

(b) copies of the key documents required for an evaluation of each issue.

78. EXPENSES OF REPRESENTATIVES (ALSO SEE SCHEDULE TO EXPENSE REGULATION FOUND IN SECTION F OF THE CODE)

78.1 The maximum amount that may be awarded to an insured person or an insurer for legal fees, is an amount calculated using:

(a) the hourly rates established under the *Legal Aid Services Act, 1998* for professional services in civil matters before the Ontario Superior Court of Justice; or

(b) the hourly rate referred to in **Rule 78.1(a)** adjusted to include, where appropriate, the experience allowance established under the *Legal Aid Services Act, 1998;*

Where an adjudicator is satisfied that a higher amount for legal fees to an insured person is justified, an hourly rate of up to **$150** may be awarded.

78.2 The maximum amount that may be awarded to an insured person or an insurer for agent's fees is an amount calculated using the hourly rates established under the *Legal Aid Services Act, 1998* for law clerks, articling students and investigators.

79. ASSESSMENT OF EXPENSES

79.1 Where an adjudicator has issued an order determining all issues in dispute except expenses, and the parties cannot agree on the entitlement to or amount of the expenses of the proceeding, either party may request, in writing, an appointment before an adjudicator to determine expenses provided that the request is made within **30 days** from the date the decision on all other issues in dispute was issued.

79.2 Where an adjudicator has issued an order of expenses to be paid and the parties cannot agree on the amounts to be paid under that order, either party may request, in writing, an appointment before an adjudicator provided that:

(a) within **30 days** from the date of the order awarding expenses, the party awarded expenses provides the other party with an account describing each of the expenses claimed, services received and the costs;

(b) the party ordered to pay expenses **must** promptly provide the other party with a written response to the account, identifying the items in dispute and the reasons for the dispute;

(c) the party awarded expenses **must** promptly provide the other party with copies of supporting documentation, such as invoices, receipts, computerized dockets or cancelled cheques in respect of the disputed items;

(d) if a dispute remains, the parties shall serve and file the above materials, together with a written request for an **assessment of expenses** upon all parties to the proceeding and legal counsel or representatives whose time and disbursements are reflected in the expenses sought;

(e) the Dispute Resolution Group shall notify the parties and their present and/or former legal counsel or representatives whether the assessment will be conducted by way of written submissions, or by an oral or electronic hearing, the date, time and if necessary, the location of the assessment hearing.

80. CONSTITUTIONAL QUESTION AND/OR CHARTER ISSUE

80.1 Where required by the *Courts of Justice Act*, a party who intends to raise a constitutional question shall serve notice of the constitutional question on the other parties and on the Attorney General of Canada and the Attorney General of Ontario at least **15 days** before the day on which the question is to be heard by the adjudicator.

80.2 The notice referred to in **Rule 80.1** must clearly set out the reasons for the question and any evidence that the party intends to rely on must be attached to the notice.

80.3 The Attorney General of Canada and the Attorney General of Ontario may intervene in the proceeding.

80.4 A constitutional question refers to the following circumstances:

(a) the constitutional validity or constitutional applicability of legislation, of a regulation or by-law made under legislation, or of a rule of common law, is in question.

(b) a remedy is claimed under subsection 24(1) of the *Canadian Charter of Rights and Freedoms*, in relation to an act or omission of the Government of Ontario.

81. WAIVER OF PROCEDURAL REQUIREMENTS

81.1 Subject to the requirements of the *Insurance Act* and the *Statutory Powers Procedure Act*, the adjudicator may on such terms as he or she considers just:

(a) set aside any time limit set out in these Rules for doing any act, serving any notice, filing any document or holding any hearing.

(b) decide that any Rule does not apply in respect of a proceeding.

45.2 The parties shall promptly provide any additional information requested by the neutral evaluator.

46. TERMINATION OF NEUTRAL EVALUATION

46.1 A party withdrawing from neutral evaluation must notify the other parties and the Dispute Resolution Group in writing.

46.2 Where a party withdraws from neutral evaluation, fails to comply with any of the requirements for neutral evaluation as set out in **Rules 44 and 45**, or fails to attend or participate in neutral evaluation, the Director may terminate the neutral evaluation.

46.3 Where neutral evaluation is terminated pursuant to **Rule 46.2**, the Director will promptly appoint an arbitrator by written notice to the parties.

46.4 **Rule 33** and following apply to an arbitration hearing conducted after the withdrawal from or termination of neutral evaluation under this Rule.

47. OPINION OF THE NEUTRAL EVALUATOR

47.1 Where neutral evaluation proceeds, the neutral evaluator will give the parties an oral opinion on the probable outcome of a proceeding in court or an arbitration.

47.2 The opinion given in neutral evaluation is for the purpose of settlement and is confidential.

47.3 A neutral evaluator shall not be required to testify in a civil proceeding or in a proceeding before any tribunal respecting the evaluation or respecting information obtained in the discharge of the neutral evaluator's duties.

48. REPORT OF THE NEUTRAL EVALUATOR

48.1 The neutral evaluator will promptly provide the parties with a **Report of the Neutral Evaluator** setting out:

(a) the issues that were evaluated;

(b) the issues that were settled; and

where any issues referred to neutral evaluation were not settled, the neutral evaluator will record:

(c) the issues that remain in dispute;

(d) the insurer's last offer in respect of such issues; and

(e) a list of materials requested by the neutral evaluator that were not provided by the parties.

48.2 No part of the oral opinion of the neutral evaluator on the probable outcome of a proceeding will be included in the **Report of the Neutral Evaluator**.

49. REFERRAL TO ARBITRATION AFTER NEUTRAL EVALUATION

49.1 If any of the issues referred to neutral evaluation are not settled, the Director shall refer the issues remaining in dispute to arbitration **2 business days** after delivery to the parties of the **Report of the Neutral Evaluator.**

49.2 The Director will promptly appoint an arbitrator.

49.3 The neutral evaluator will not preside at the arbitration hearing.

49.4 **Rule 37** and following, apply to an arbitration hearing conducted after neutral evaluation is completed and the parties have not settled an issue in dispute.

PART 4 – APPEAL OF ARBITRATION ORDER

50. APPEAL

50.1 A party to an arbitration may appeal an order of an arbitrator to the Director only on a question of law.

50.2 A party may not appeal a preliminary or interim order of an arbitrator until all of the issues in dispute in the arbitration have been finally decided, unless the Director orders otherwise.

50.3 An appeal does not stop an arbitration order from taking effect, unless the Director orders otherwise.

51. STARTING AN APPEAL

51.1 To appeal an arbitration order, the appellant must:

(a) complete a ***Notice of Appeal*** in **FORM I** ;

(b serve a copy of the ***Notice of Appeal*** on the respondent's lawyer or if the respondent was not represented by a lawyer at the arbitration hearing, on the respondent;

(c) file the ***Notice of Appeal*** and a ***Statement of Service*** in **FORM F**; and

(d) pay the application filing fee set out in **Section D** of the **Code**.

51.2 An appeal may be rejected if:

(a) it is out of time;

(b) it does not raise a question of law;

(c) it is from a preliminary or interim order that does not finally decide the issues in dispute;

(d) the ***Notice of Appeal*** is incomplete or lacks sufficient details to allow the other party to respond; or

(e) the appellant does not pay the required application filing fee.

51.3 If the Director determines that a ***Notice of Appeal*** is incomplete or is rejected under **Rule 51.2,** the Director will notify the parties and their representatives of the rejection.

51.4 Upon receipt of a properly completed ***Notice of Appeal, Statement of Service*** and the application filing fee, the Director will promptly acknowledge the appeal.

52. TIME FOR APPEAL

52.1 Subject to **Rule 52.2**, the appellant must file the ***Notice of Appeal*** within **30 days** of the date of the arbitration order.

52.2 The Director may extend the time for requesting an appeal on such terms as he or she considers appropriate, either before or after the **30-day** time limit, if he or she is satisfied there are reasonable grounds for granting the extension.

53. RESPONSE TO APPEAL

53.1 Within **20 days** of receiving the Director's acknowledgment of the ***Notice of Appeal*** (see **Rule 51.4**), a respondent must:

(a) complete a ***Response to Appeal*** in **FORM J**;

(b) serve the ***Response*** on the appellant's representative or if not represented, on the appellant; and

(c) file a copy of the ***Response*** and a ***Statement of Service*** in **FORM F**.

54. WRITTEN SUBMISSIONS

54.1 Unless the Director orders otherwise, the appellant must:

(a) serve and file written submissions within **30 days** of the date on which the ***Response to Appeal*** was due; and

(b) file a ***Statement of Service*** in **FORM F**.

54.2 If a transcript has been ordered, the time limit for the appellant's written submissions set out in **Rule 54.1(a)** is extended to **30 days** from the date on which the transcript is received.

See **Rule 74** regarding transcripts.

54.3 Within **20 days** of receiving the appellant's written submissions, the respondent must:

(a) serve on the appellant and any other parties any written submissions upon which the respondent intends to rely; and

(b) file the written submissions and a ***Statement of Service*** in **FORM F**.

55. APPEAL BY RESPONDENT ("CROSS-APPEAL")

55.1 If the respondent intends to appeal the arbitration order, a separate ***Notice of Appeal*** must be completed and the time periods for appeal, as set out above, apply.

56. THE APPEAL PROCESS

56.1 The Director may appoint a person to conduct the appeal on his or her behalf and to exercise the powers and perform the duties of the Director relating to the appeal.

56.2 An order made by a person appointed under **Rule 56.1** is considered an order of the Director.

56.3 Unless the Director orders otherwise, an appeal will only include issues that were the subject of the arbitration proceeding or dealt with in the arbitration order being appealed.

56.4 The **appeal record** includes the ***Notice of Appeal***, the ***Response to Appeal***, the written submissions of the parties, and the record of the arbitration hearing, including all arbitration exhibits and, if it is filed, the transcript of the arbitration hearing.

56.5 The Director may decide the appeal:

(a) on the record;

(b) by way of an oral hearing or an electronic hearing; or

(c) in any other manner that the Director considers appropriate.

56.6 If the Director decides to schedule an oral or electronic hearing, a **Notice of Hearing** will be delivered to the parties and their representatives.

57. PRELIMINARY CONFERENCE

57.1 The Director may require the parties to participate in one or more preliminary conferences.

57.2 **Rule 33** applies with necessary changes to a preliminary conference held under this Part.

58. NON-PARTICIPATION

58.1 The Director may proceed with an appeal even though a party fails to file any document required by these Rules.

58.2 Where a ***Notice of Hearing*** has been delivered to a party, and the party does not attend, the Director may proceed with the oral submissions or the hearing in the absence of the party, and the party is not entitled to any further notice in the proceeding.

59. INTERVENTIONS

59.1 The Director may request persons who are not parties to an appeal to make submissions on any issue of law arising in an appeal, and participation will be on such terms as the Director considers appropriate.

59.2 Persons who are not parties to an appeal may apply to make submissions on an issue of law arising in an appeal.

59.3 A person who wishes to make submissions on an issue of law arising in an appeal must:

(a) complete an ***Application for Intervention*** in **FORM K**;

(b) serve a copy of the ***Application*** on the representative of each of the parties to the appeal or, if a party is not represented, on the party; and

(c) file the ***Application*** and a ***Statement of Service*** in **FORM F**.

59.4 An ***Application for Intervention*** may be rejected if it does not include:

(a) the applicant's reasons for wishing to participate; and

(b) a summary of the applicant's submissions on the issues of law.

59.5 Where an ***Application for Intervention*** is rejected, the Director will notify the applicant and the representative of each of the parties to the appeal or, if a party is not represented, the party.

59.6 Within **10 days** of receiving an ***Application for Intervention***, a party may indicate that he or she supports or objects to the intervention by:

(a) filing his or her written comments; and

(b) sending a copy of his or her written comments to the representative of the applicant or, if not represented, to the applicant.

60. THE INTERVENTION PROCESS

60.1 **Rules 56, 57 and 58** apply with necessary changes.

PART 5 – VARIATION OR REVOCATION OF AN ORDER

61. APPLICATION FOR VARIATION/REVOCATION

61.1 Either the insured person or the insurer may apply to the Director to vary or revoke an arbitration order or an appeal order if:

(a) there has been a material change in the circumstances of the insured;

(b) evidence not available on the arbitration or appeal has become available; or

(c) there is an error in the order.

61.2 A party may not apply to vary or revoke a preliminary or interim order of an adjudicator until all of the issues in dispute in the proceeding have been finally decided, unless the Director orders otherwise.

61.3 A party seeking to have an arbitration order or an appeal order varied or revoked must:

(a) complete an ***Application for Variation/Revocation*** in **FORM L**;

(b) serve a copy of the ***Application*** on the respondent's lawyer or, if not represented by a lawyer, on the respondent;

(c) file the ***Application*** and a ***Statement of Service*** in **FORM F**; and

(d) pay the application filing fee set out in **Section D** of the **Code**.

61.4 The ***Application for Variation/Revocation*** may be rejected if:

(a) it is from a preliminary or interim order that does not finally decide the issues in dispute;

(b) it is incomplete or lacks sufficient details to allow the other party to respond;

(c) it is in respect of an order that has been appealed, and the appeal is pending; or

(d) the applicant does not pay the required application filing fee.

61.5 If the Director determines that the ***Application for Variation/Revocation*** is incomplete or is rejected under **Rule 61.4**, the Director will notify the parties and their representatives of the rejection.

61.6 The Director will promptly acknowledge the ***Application for Variation/Revocation*** upon receipt of a properly completed ***Application, Statement of Service*** and the application filing fee.

62. RESPONSE TO THE APPLICATION FOR VARIATION/REVOCATION

62.1 Within **20 days** of receiving the Director's acknowledgment of the ***Application for Variation/Revocation*** (see **Rule 61.6**), a respondent must:

(a) complete a ***Response to Application for Variation/Revocation*** in **FORM M**;

(b) serve the ***Response*** on the applicant's representative or if not represented, on the applicant; and

(c) file a copy of the ***Response*** and a ***Statement of Service*** in **FORM F**.

63. THE VARIATION/REVOCATION PROCESS

63.1 The Director may:

(a) decide the ***Application for Variation/Revocation***;

(b) delegate a person to decide the ***Application for Variation/Revocation*** on his or her behalf and to exercise the powers and perform the duties of the Director in relation to the ***Application***; or

(c) appoint the same adjudicator who made the original order or another adjudicator to decide the ***Application for Variation/Revocation***.

63.2 **Rules 54, 57 and 58** apply to an ***Application for Variation/Revocation*** with necessary changes.

64. APPLICABILITY OF THIS PART

64.1 This Part applies to all arbitrations, appeals, interventions and variation/revocation proceedings.

65. ORDERS

65.1 An adjudicator will determine the issues before him or her by order and may make an order subject to such terms as he or she considers just.

65.2 An adjudicator may make an oral order with oral reasons where he or she considers it appropriate. The adjudicator will confirm the provisions of an oral order in writing if requested by the parties at the conclusion of the oral order.

65.3 An order which finally decides the issues in dispute will be supported by written reasons.

65.4 The Dispute Resolution Group will deliver a copy of the order and the adjudicator's written reasons, if any, to the parties.

65.5 An adjudicator may, at any time, correct a typographical error, error of calculation, technical error or similar error made in his or her decision or order.

65.6 An adjudicator may at any time clarify a decision or order that contains a misstatement, ambiguity or other similar error.

65.7 An adjudicator may make such orders or give such directions as he or she considers proper to prevent an abuse of process.

66. COURT ENFORCEMENT OF ORDERS

66.1 On written request, the Director will provide a party with a certified copy of an order.

66.2 A party may file a certified copy of an order in the Ontario Superior Court of Justice and the order can be enforced by the Court in the same manner as an order of that Court.

66.3 A party who files an order under **Rule 66.2** shall notify the Director within **10 days** after the filing.

67. ORDERS WITHIN PROCEEDING: MOTIONS

67.1 An adjudicator may make preliminary or interim orders within a proceeding, pending a final order.

67.2 A party may request a preliminary or interim order, at any stage within a proceeding, pending a final order.

67.3 A party making such a request must, in writing:

(a) describe the order being sought, the grounds for the order, and provide any documents to be relied on;

(b) set out the time, date and manner in which the party seeks to have the motion heard; and

(c) serve this material on the parties and file it.

67.4 Where a party seeks an order for production against a person who is not a party to the proceeding ("third party"), the party making the request must serve the materials required under **Rule 67.3**, upon the third party and file it together with a ***Statement of Service*** in **FORM F**.

67.5 Within **10 days** of being served, the responding party and third party, if any, must:

(a) serve a written response and documents to be relied on; and

(b) file a copy of the written response and documents.

67.6 The adjudicator may determine the request on the basis of the documents and written submissions filed, or in such manner as the adjudicator considers appropriate.

67.7 Before making an order for the production of documents against a third party, the adjudicator shall be satisfied that:

(a) the parties have made reasonable efforts to obtain the document sought;

(b) the document sought is in the possession, control or power of the third party;

(c) the third party has had a reasonable opportunity to respond;

(d) the document is reasonably required to ensure a just and fair hearing.

67.8 A request for an interim order or an order on a preliminary issue may also be made orally during a pre-hearing discussion, a preliminary conference, or at a hearing, and will be dealt with in such manner as the adjudicator considers appropriate.

68. DISMISSAL OF PROCEEDING WITHOUT HEARING

68.1 Subject to **Rule 68.2**, an adjudicator may dismiss a proceeding without a hearing where the proceeding is frivolous, vexatious or is commenced in bad faith;

68.2 Before dismissing a proceeding under this Rule, the Registrar or an adjudicator shall deliver written notice to all parties of the intention to dismiss the proceeding on the grounds set out in **Rule 68.1.**

68.3 Where a party objects to a dismissal of the proceeding pursuant to **Rule 68.1** or seeks to make written submissions with respect to the dismissal, the party must:

(a) provide the grounds upon which the party objects to the dismissal of the proceeding, or set out any other issues or concerns, in writing; and

(b) serve the material upon the Registrar and all other parties within **20 days** of the date of the notice provided under **Rule 68.2.**

68.4 An adjudicator will consider any written objections or submissions received and may make an order on such terms as he or she considers just.

69. SETTLEMENT

69.1 The parties may settle any or all issues in dispute at any time. The Dispute Resolution Group will close its file:

(a) immediately upon receipt of written confirmation from the parties that the entire matter is settled; or

(b) **20 days** following notice of the Dispute Resolution Group's intention to close the file on the basis of a reported settlement.

69.2 Where a party objects to the closure of the file under **Rule 69.1(b),** the party must promptly notify the Dispute Resolution Group and all other parties, in writing, setting out the reasons for the objection.

69.3 Either party may request an adjudicator to issue an order dismissing the proceeding on consent of the parties, upon filing:

(a) a consent, signed by the parties or their representatives, stating that they consent to the dismissal of the arbitration and confirming that no party to the proceeding is under a disability;

(b) the terms of any settlement reached by the parties with an acknowledgment by the parties that they have reviewed the provisions of the **Regulation** governing settlement, found in **Section E** of the **Code**;

(c) the written agreement of the parties that the consent order is final and shall not be subject to appeal, variation/revocation, or judicial review; an

(d) sufficient copies of the consent order, approved as to form and content by the parties, for delivery by the Dispute Resolution Group.

70. WITHDRAWAL

70.1 A party may seek permission to withdraw all or part of a dispute by:

(a) serving a request to withdraw on all parties; and

(b) filing the request to withdraw together with a ***Statement of Service*** in **FORM F**; or

(c) making an oral request to withdraw all or part of a dispute during a neutral evaluation, pre-hearing discussion, settlement discussion, preliminary conference or at a hearing.

70.2 The Registrar or an adjudicator may permit a party to withdraw where all parties agree.

70.3 Where a party does not agree to the withdrawal, an adjudicator may:

(a) permit the withdrawal on such terms and conditions as he or she considers just;

(b) award expenses to either party as permitted by **Rule 75** and following, and the **Expense Regulation** under **Section F** of the **Code**;

(c) award an amount to the insurer, up to the amount of the assessment the insurer is required to pay to participate in the hearing, where the adjudicator is of the opinion that the insured person commenced an arbitration that was frivolous, vexatious or an abuse of process.

71. INABILITY OF AN ADJUDICATOR TO COMPLETE A HEARING

71.1 If an adjudicator becomes unable, for any reason, to complete a hearing or issue a decision, the matter may be reheard by a new adjudicator appointed by the Director.

71.2 Where a transcript of the incomplete hearing is available, the Director may notify the parties of the Director's intention to provide a copy of the transcript to the new adjudicator, with a copy to the parties, at the Dispute Resolution Group's expense; where the Director considers it appropriate, or where the parties agree and the Director approves.

71.3 Where a party objects to the use of the transcript by the new adjudicator, the party must promptly notify the Director and all other parties in writing, setting out the reasons for the objection.

72. ADJOURNMENTS

72.1 A request for an adjournment of a pre-hearing discussion or an arbitration proceeding must be made in writing to the Registrar. A request for an adjournment of an appeal or variation/revocation must be made in writing to the Director. Such requests must:

(a) outline the reasons for the adjournment;

(b) indicate whether all parties consent to the adjournment; and

(c) provide alternative dates that are acceptable to all parties.

72.2 A request for an adjournment must be served on the other parties and filed **7 days** in advance of the scheduled proceeding or in such lesser period of time as the Registrar, the Director or an adjudicator may permit.

72.3 In deciding whether an adjournment is appropriate, the Registrar, the Director or an adjudicator shall refer to the **Adjournments Policy** found in **Practice Note 9** under **Section C** of the **Code**.

72.4 An adjudicator may adjourn a proceeding on his or her own initiative, or at the request of a party, on such terms he or she considers just.

72.5 An adjudicator may require the parties to attend in person to argue an adjournment, even if it is on consent.

73. SUMMONS TO WITNESS

73.1 An adjudicator has the same powers to summons as a judge of the Ontario Superior Court of Justice. The adjudicator may, by ***Summons to Witness***, require a person to:

(a) attend at or participate in a hearing, and to give evidence on oath or otherwise; and

(b) produce in evidence documents and things set out in the summons.

73.2 If a person does not attend or participate in a hearing or does not produce the documents listed in the ***Summons to Witness*** (**FORM N**), a judge of the Ontario Superior Court of Justice may order that a warrant for the arrest of that person be issued or that the person be punished in the same way as for contempt of that court.

73.3 A ***Summons to Witness*** must be prepared in **FORM N**.

73.4 The party requesting the summons must:

(a) ensure that the ***Summons to Witness*** is served personally on the person summoned not less than **5 business days** before the first day of the hearing, or within such shorter time period as the adjudicator considers just;

(b) pay the person summoned the same fees or allowances as are paid to a person summoned to attend before the Ontario Superior Court of Justice; and

(c) file an ***Affidavit of Service for a Summons to Witness*** in **FORM O** as proof that the ***Summons*** was properly served and that the required fees or allowances have been paid.

> See **Practice Note 8** "Attendance of a Witness to an Arbitration Hearing by Summons" found in **Section C** of the **Code**.

73.5 An adjudicator may excuse a witness from the obligation to attend at or participate in a hearing where notice under **Rules 33, 41 and 73.3** has not been provided to the witness.

74. TRANSCRIPTS

74.1 A hearing may be recorded by a court reporter who has taken an oath or affirmation to report the evidence and proceedings faithfully. The Dispute Resolution Group does not provide reporting services for a hearing. Parties who want a record of the proceedings must make their own arrangements for the attendance of a reporting service, and must pay for this service.

74.2 Where a party hires a reporting service to record the proceedings, the party must:

(a) inform the other parties and the adjudicator;

(b) make the necessary arrangements for the reporting service; and

(c) directly pay the person or agency providing the reporting service.

74.3 Where a party orders all or a portion of the transcript of a proceeding, the party must:

(a) inform the other parties and the adjudicator;

(b) provide a copy of the transcript to the other party and the adjudicator; and

(c) directly pay the person or agency providing the transcript.

75. AWARD OF EXPENSES

75.1 An adjudicator may award expenses to a party if the adjudicator is satisfied that the award is justified having regard to the criteria set out in **Rule 75.2.** The items and amounts which may be awarded are found in **Rule 78** and the **Schedule** to the **Expense Regulation** found in **Section F** of the **Code**.

75.2 The adjudicator will consider the criteria referred to in the **Expense Regulation** found in **Section F** of the **Code.** These criteria are:

(a) each party's degree of success in the outcome of the proceeding;

(b) conduct of the insurer or the insured person that tended to shorten or facilitate the proceeding or that tended to prolong, obstruct or hinder the proceeding, including failure to comply with undertakings or orders;

(c) whether the proceeding or any position taken by the insurer or the insured person during the proceeding was manifestly unfounded, frivolous, vexatious, fraudulent or an abuse of process;

(d) the degree of complexity, novelty or significance of the factual or legal issues raised in the proceeding;

(e) at the request of either party, any written offer to settle made in accordance with **Rules 76** and **77**, having regard to the outcome of the proceeding;

(f) any other matter related to the proceeding that the adjudicator considers relevant to the issue of whether an award of expenses is justified.

76. OFFER TO SETTLE

76.1 An adjudicator will consider an **Offer to Settle** in connection with an award of expenses provided that:

(a) it was made in writing, was served on the other parties and contains:

(i) the full terms of the **Offer to Settle;**

(ii) the date when the **Offer** was served and the time period during which it remained open for acceptance;

AND

(b) the **Offer** was made after the conclusion of mediation and before the conclusion of the hearing, with particular consideration given to any **Offer** served after the conclusion of the pre-hearing discussion or preliminary conference as the case may be, up to 5 days before the commencement of the hearing.

76.2 **Response to an Offer to Settle** will be considered provided that:

(a) it was made in writing, indicates the **Offer** to which it relates; and

(b) it was served upon the other parties before the conclusion of the hearing.

76.3 An **Offer to Settle** or **Response to an Offer to Settle** may be withdrawn at any time before it is accepted, by serving written notice of the withdrawal on the party to whom the offer or response was made.

76.4 An **Offer** or **Response** will expire on the earlier of the expiry date stated in the **Offer** or **Response**, or at the conclusion of the hearing.

76.5 Acceptance of an **Offer** or **Response** must be made in writing and served upon the party making the **Offer** or **Response**, prior to the withdrawal or expiry of the offer.

77. COMMUNICATION OF AN OFFER TO SETTLE OR RESPONSE TO AN OFFER TO SETTLE

77.1 When no party to an adjudication seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses, the parties will jointly inform the adjudicator of that fact at the conclusion of the hearing; and the adjudicator will make an award of expenses as part of his or her order on the substantive issues in dispute.

77.2 Where any party seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses, the parties will jointly advise the adjudicator of that fact at the conclusion of the hearing.

77.3 Upon such advice, the adjudicator will determine all issues in dispute, except expenses and issue his or her order.

77.4 The Dispute Resolution Group will deliver a copy of the order (excluding expenses) and the adjudicator's written reasons, if any, to the parties.

77.5 Within **10 days** of the delivery of the order, either party may file any relevant **Offer to Settle** or **Response to an Offer to Settle** which was made in accordance with **Rule 76**, for consideration by the adjudicator in connection with an award of expenses.

77.6 Either party may request an appointment before an adjudicator for an award of expenses or an assessment of expenses in accordance with **Rule 79**.

81.2 Any procedural requirement set out in the *Insurance Act* or the *Statutory Powers Procedure Act* that applies to a hearing held under these Rules may be set aside with the agreement of the parties and the adjudicator.

82. TESTIMONY AND CIVIL PROCEEDINGS

82.1 Except with the consent of the Superintendent of Financial Services, no adjudicator shall be required to testify in a civil proceeding, in a proceeding before the Superintendent or in a proceeding before any other court or tribunal respecting information obtained in the discharge of his or her duties.

SECTION B – GUIDELINES

1. Guideline for Identifying Self-employed Individuals ..... B 1-1

2. Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process (Bill 59) ..... B 2-1

3. Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process ..... B 3-1

4. Guideline for selecting the Nearest Designated Assessment Centre ..... B 4-1

5. Guideline for Identifying Students Who Qualify for The Student Non-Earner Benefit (Bill 59) ..... B 5-1

6. Guideline for Identifying Individuals Who Qualify for Education Disability Benefits ..... B 6-1

7. Guideline on the Management of Claims Involving Whiplash-Associated Disorders ..... B 7-1

8. Optional Indexation Benefit Guidelines ..... B 8-1

9. Transportation Expense Guidelines ..... B 9-1

10. Transportation Expense Guidelines (Effective March 31, 2001) ..... B 10-1

11. Guideline Respecting Conflict of Interest in the Provision of Medical and Rehabilitation Services ..... B 11-1

GUIDELINE FOR IDENTIFYING SELF-EMPLOYED INDIVIDUALS

This guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

This guideline applies to all accidents occurring on or after January 1, 1994, including accidents on or after November 1, 1996, and should be used when it has already been established that the individual is employed, but it is unclear whether the individual is self-employed or what the relationship is between the individual and an employer. Under the *Statutory Accident Benefits Schedule (SABS)* self- employment income is treated differently than employment income.

For the purposes of the *SABS*, an individual is considered to be self-employed if the business he or she derives his or her remuneration from is not incorporated under any law. For example, sole proprietorships and partnerships are considered to be self-employment situations. If the individual derives his or her remuneration from an incorporated business, then he or she is considered to be an employee of the corporation.

DEFINITIONS

Business	An activity that is carried on for profit or with a reasonable expectation of profit, including a profession, a calling, a trade, a manufacture or undertaking of any kind, an adventure or concern in the nature of trade, or a service.
Employee	An individual who is hired to perform pre-determined tasks/work in a business in exchange for remuneration.
Employer	An entity, such as a corporation, group of individuals or a single individual, who hires another individual(s) to perform pre-determined tasks/work in a business in exchange for remuneration.
Purchaser	An entity, such as a corporation, group of individuals or a single individual, that enters into an agreement or contract for service(s) with another individual in exchange for a negotiated remuneration.

The following sets out indicators of self-employment in two situations:

1. TRADITIONAL SELF-EMPLOYMENT SITUATION

THE INDIVIDUAL:

- is an owner of an unincorporated sole proprietorship or a partner in a partnership (other than a limited partner).
- has an established location where business transactions take place.
- participates in the everyday operations of the business (not just an investor or receiving remuneration for purposes of income splitting).
- determines own method and schedule for accomplishing tasks.
- determines own hours and may not necessarily work a set number of hours per period (i.e. 40 hour week).
- negotiates the price(s) of product(s) or fee(s) for service(s) with the customer or client with the exception of regulated fields (i.e. physicians).
- determines the annual income as his or her profit from the business according to the Income Tax Act (Canada) and Income Tax Act (Ontario).
- is ineligible for regular Employment Insurance benefits.
- contributes the employer and employee contributions to Canada Pension Plan (CPP) for his or her own pension plan.
- collects and remits all taxes to different levels of government according to each respective tax legislation (i.e. GST, PST, source deductions from employee(s)).

IN THE CASE OF A SOLE PROPRIETORSHIP:

- has control over:
  (1) the hiring and dismissal of employee(s),
  (2) the wage level and hours of work of employee(s),
  (3) the method by which employee(s) accomplish work, and
  (4) executive decisions surrounding the business.

IN THE CASE OF A PARTNERSHIP:

- has some or all control, depending on agreements with his or her partner(s) over:
  (1) the hiring and dismissal of employee(s),
  (2) the wage level and hours of work of employee(s),

(3) the method by which employee(s) accomplish work, and
(4) executive decisions surrounding the business.

Examples: (1) owner/operator or partner of a restaurant, convenience store, etc.
(2) physician in private practice

2. CONTRACT OF SERVICE SITUATION

THE INDIVIDUAL:

- has contract work with no long-term or permanent relationship to a specific purchaser.
- is providing the actual service(s) which may be performed at one or more locations for one or more purchasers over the same period of time.
- determines own method and schedule for accomplishing tasks.
- determines own hours and may not necessarily work a set number of hours per period (i.e. 40 hour week).
- negotiates fees for services provided to the purchaser.
- has a business-relationship with a purchaser(s) evidenced by a contract or agreement, either written or oral, express or implied, usually providing some sort of labour.
- does not hire any employees.
- is ineligible for regular Employment Insurance benefits.
- contributes the employer and employee contributions to CPP for his or her own pension plan.
- determines the annual income as his or her profit from the business according to the *Income Tax Act (Canada) and Income Tax Act (Ontario).*

Examples: 1) Independent cleaners
2) Independent truck driver
3) Handyman
4) Limousine driver

GUIDELINE FOR STATUTORY ACCIDENT BENEFITS APPLICATIONS, THE CLAIMS PROCESS AND THE MEDIATION PROCESS (BILL 59)

This guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

This guideline applies to accidents occurring on or after November 1, 1996. The purpose of this guideline is to help insurers and claimants understand their rights and responsibilities when dealing with statutory accident benefit claims. Above all else there is an obligation on both insurers and insured persons (referred to as "claimants" in this guideline) to act fairly with each other in making an application for benefits and in processing claims.

The full and timely exchange of information by both insurers and claimants is critical. Insurers must limit their requests to information that is related to the claim, and claimants must give an insurer the information that the company needs to establish the nature, extent and continuing validity of a claim. Claimants must not withhold any information, delay, make the insurer's evaluation of the claim more difficult or impossible.

Claimants should realize that unreasonable actions will delay payments and can lead to denial of benefits without access to court or arbitration. Insurers can also terminate benefits if a claimant wilfully misrepresents facts with respect to an application for accident benefits.

Insurers should realize that unreasonable actions are treated as unfair practices and may lead to penalties under Section 282(10) of the Insurance Act, cease and desist orders and prosecution.

This guideline applies equally to all insurers, claimants and their representatives and is to be considered in any decision involving the interpretation of the *Statutory Accident Benefits Schedule (SABS)*. The details of the rights and responsibilities of the parties are set out in the sections called "Principles For Statutory Accident Benefits Applications And The Claims Process" and "Principles For The Mediation Process."

PRINCIPLES FOR STATUTORY ACCIDENT BENEFITS APPLICATIONS AND THE CLAIMS PROCESS

INSURERS' RESPONSIBILITIES

- Inform claimants about the kind of accident benefits that are available under the *SABS*, let claimants know all the procedures to be followed and documentation needed when applying for benefits. When asked, insurers

must give a copy of the *SABS* without charge to any person entitled to benefits.

- Give claimants the application for benefits package and other applicable forms, and help claimants complete all forms.
- Provide claimants with specific requests for additional relevant information.
- Make sure that all requests for information from claimants and third parties are relevant to the claimant's entitlement to benefits.
- Evaluate all applications for benefits fairly and quickly.
- Let claimants know about all decisions made concerning their claim within the times specified in the *SABS*, give the reasons for those decisions, and make sure that payments due to claimants are made within the times specified in the *SABS*.
- Pay for reasonable measures to reduce or eliminate the effects of any disability resulting from injuries sustained by a claimant in an accident and to help their reintegration into their family, the labour market and the rest of society.
- Cooperate with representatives retained or appointed by claimants to help claimants with their claims.
- Make sure notices to claimants are in writing and in plain language.
- Make sure requests for a claimant to undergo an assessment or examination are to obtain necessary information.
- Make sure assessors or evaluators who are asked by the insurer to examine a claimant accommodate the claimant when scheduling appointments to minimize inconvenience to the claimant.

Claimants' Responsibilities

- Complete all forms promptly. The *SABS* require that applications for accident benefits be submitted within 30 days of receiving the forms from the insurer.
- Give their insurer all reasonably relevant information requested by the insurer to prove their entitlement to benefits including a statutory declaration as to the circumstances that gave rise to the accident benefits application.
- Give true and accurate information.

- Give third parties the right to release information about the claimant needed by insurers to evaluate the claim for benefits.
- Submit a treatment plan before incurring medical or rehabilitation expenses.
- Take part in treatment and rehabilitation that will allow them to start or return to work, or shorten their period of disability.
- Cooperate with representatives retained or appointed to help insurers evaluate claims.
- Promptly let their insurer know about any material change in their circumstances affecting their entitlement to benefits (the *Insurance Act* requires that this be done within 14 days).
- Take part in assessments or examinations that their insurer is allowed to ask for under the *SABS* including those done by designated assessment centres (DACs).
- Give notice (under normal circumstances, notice should be given within 2 days) to their insurer and the assessor or examiner when they cannot attend a scheduled appointment and give reasons why they cannot attend.
- Give any person allowed to examine or assess the claimant under the *SABS*, the information that is reasonably necessary to do the examination and allow third parties to also give out such information.
- Agree to have reports produced by persons allowed to examine the claimant under the *SABS* given to your insurer.

PRINCIPLES FOR THE MEDIATION PROCESS

A) Responsibilities of claimants wishing to apply for mediation services

- have previously completed an application for benefits and all forms in full and submitted them to your insurer; and
- take part in any assessment or examination required under the *SABS*, and give the assessor any information needed for an assessment under the *SABS*.

B) Responsibilities of insurers and claimants before using mediation services at the Ontario Insurance Commission

- clarify the facts;
- identify the issues in dispute according to both of them;

- discuss and arrange for the timely exchange of relevant documents; and
- make reasonable efforts towards reaching a settlement.

C) **Other responsibilities of claimants**

- personally take part and cooperate in the mediation process.

GUIDELINE FOR STATUTORY ACCIDENT BENEFITS APPLICATIONS, THE CLAIMS PROCESS AND THE MEDIATION PROCESS

This Guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

The purpose of this Guideline is to help insurers and claimants understand their rights and responsibilities when dealing with statutory accident benefit claims. Above all else there is an obligation on both insurers and insured persons (referred to as "claimants" in this guideline) to act fairly with each other in making an application for benefits and in processing claims. The full and timely exchange of information by both insurers and claimants is critical.

However, insurers must limit their requests to information that is related to the claim. Likewise, claimants must give an insurer the information that the company needs to establish the nature, extent and continuing validity of a claim. Claimants must not withhold any information, delay, make more difficult or impossible the insurer's evaluation of the claim. Set out in the sections called "Principles For Statutory Accident Benefits Applications And The Claims Process" and "Principles For The Mediation Process" are the details of the rights and responsibilities of the parties. This Guideline applies equally to all insurers, claimants and their representatives and is to be considered in any decision involving the interpretation of the *Statutory Accident Benefits Schedule (SABS)*.

Claimants should realize that unreasonable actions will delay payments and can lead to denial of benefits without access to court or arbitration.

Insurers should realize that unreasonable actions are treated as unfair practices and may lead to penalties under Section 282(10) of the *Insurance Act*.

PRINCIPLES FOR STATUTORY ACCIDENT BENEFITS APPLICATIONS AND THE CLAIMS PROCESS

INSURERS' RESPONSIBILITIES

- Inform claimants about the kind of accident benefits that are available under the *SABS*, let claimants know all the procedures to be followed and documentation needed when applying for benefits. When asked, insurers must give a copy of the *SABS* without charge to any person entitled to benefits.

**This guideline applies to Bill 164-Accidents After December 31, 1993 and Before November 1, 1996, as per OIC Bulletin No. A-12/96*

- Give claimants the application for benefits package and other applicable forms, and help claimants complete all forms.
- Provide claimants with specific requests for additional relevant information.
- Make sure that all requests for information from claimants and third parties are relevant to the claimant's entitlement to benefits.
- Evaluate all applications for benefits fairly and quickly.
- Let claimants know about all decisions made concerning their claim within the times specified in the *SABS*, give the reasons for those decisions, and make sure that payments due to claimants are made within the times specified in the *SABS*.
- Pay for reasonable measures to reduce or eliminate the effects of any disability resulting from injuries sustained by a claimant in an accident and to help their reintegration into their family, the labour market and the rest of society.
- Cooperate with representatives retained or appointed by claimants to help claimants with their claims.
- Make sure notices to claimants are in writing and in plain language.
- Make sure requests for a claimant to undergo an assessment or examination are to obtain necessary information.
- Make sure assessors or evaluators who are asked by the insurer to examine a claimant accommodate the claimant when scheduling appointments to minimize inconvenience to the claimant.

CLAIMANTS' RESPONSIBILITIES

- Complete all forms promptly.
- Give their insurer all reasonable relevant information asked for by the insurer to prove their entitlement to benefits.
- Give true and accurate information.
- Give third parties the right to release information about them needed by insurers to evaluate their claim for benefits.
- Take part in treatment and rehabilitation that will allow them to start or return to work, or shorten their period of disability.
- Cooperate with representatives retained or appointed to help insurers evaluate claims.

- Promptly let their insurer know about any change in their situation affecting their entitlement to benefits (under normal circumstances, this should be done within 14 days).

- Take part in assessments or examinations that their insurer is allowed to ask for under the *SABS* including those done by designated assessment centres (DACs).

- Give notice (under normal circumstances, notice should be given within 2 days) to their insurer and the assessor or examiner when they cannot attend a scheduled appointment and give reasons why they cannot attend.

- Give any person allowed to examine or assess the claimant under the *SABS*, the information that is reasonably necessary to do the examination and allow third parties to also give out such information.

- Agree to have reports produced by persons allowed to examine the claimant under the *SABS* given to their insurer.

PRINCIPLES FOR THE MEDIATION PROCESS

A) **Responsibilities of claimants wanting to apply for mediation services**

- completed an application for benefits and all forms in full; and

- take part in any assessment or examination required under the *SABS*, and give the information needed for an assessment under the *SABS*.

B) **Responsibilities of insurers and claimants before using mediation services at the Ontario Insurance Commission**

- clarify the facts;

- identify the issues in dispute according to both of them;

- discuss and arrange for the timely exchange of relevant documents; and

- make reasonable efforts towards reaching a settlement.

C) **Other responsibilities of claimants**

- personally take part in the mediation process.

GUIDELINE FOR SELECTING THE NEAREST DESIGNATED ASSESSMENT CENTRE

This Guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

The purpose of this Guideline is to assist insurers and claimants in arranging assessments at Designated Assessment Centres (DACs) at the earliest convenient time and to resolve operational and interpretive issues concerning the selection of a DAC that is nearest to the residence of an insured person.

Sections 39, 45, 50, and 64 of the Statutory Accident Benefits Schedule (SABS) provides that where an assessment is requested, it is conducted by the DAC "nearest to the residence of the insured person" that is authorized to assess impairments of the type sustained by the insured person.

It is expected that the DAC will promptly arrange for the assessment. The Guidelines for Designated Medical and Rehabilitation Assessment Centres, Guidelines for Designated Disability Assessment Centres, and Guidelines for Designated Attendant Services Assessment Centres established by the Accident Benefits Advisory Committee set out a time frame of 14 days for the intake phase of the assessment process once the complete referral package is received. This phase includes setting up appointments with the assessor(s). This standard was established to ensure that insurers and claimants are provided with opinions regarding disability or treatment and services as quickly as possible.

However, DACs may not always be able to accommodate referrals within the 14-day time frames established by the Accident Benefits Advisory Committee because of volume, staff vacations and other commitments. In these instances, insurers and insured persons should interpret the SABS as requiring the assessment to be conducted by the DAC next closest to the claimant's residence that can accommodate the parties within 14 days of receiving the complete referral.

Where a DAC is unable to meet the 14-day time frame, it should advise the insurer arranging the DAC assessment and confirm this in writing, in order to allow the next nearest DAC to be notified without delay.

**This guideline applies to Bill 164-Accidents After December 31, 1993 and Before November 1, 1996, as per OIC Bulletin No. A-12/96*

GUIDELINE FOR IDENTIFYING STUDENTS WHO QUALIFY FOR THE STUDENT NON-EARNER BENEFIT (BILL 59)

This guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

This guideline applies to accidents occurring on or after November 1, 1996 and is to be considered when determining whether an insured person qualifies for the non-earner benefit as a student or as someone who has recently completed his or her education at the time of the accident.

For the purposes of the *Statutory Accident Benefits Schedule (SABS)*, an individual may qualify for non-earner benefits if he or she, at the time of an accident:

1. was enrolled on a full-time basis in elementary education;
2. was enrolled on a full-time basis in secondary education;
3. was enrolled on a full-time basis in post-secondary education;
4. completed his or her education within one year prior to the accident.

Elementary education	includes kindergarten to grade eight at a public school, separate school or private school of equivalent level, approved by the minister responsible for education or comparable education level in other jurisdictions approved by a comparable authority.
Secondary education	includes grades nine to thirteen or equivalent, at a school that is under the jurisdiction of a public or separate school board or a private school of equivalent level, approved by the minister responsible for education or comparable education level in other jurisdictions approved by a comparable authority.
Post-secondary education	includes programs taken at community colleges, universities and equivalent institutions approved by the minister responsible for education or education programs taken at institutions in other jurisdictions with approval by a comparable authority.

An individual is eligible for non-earner benefits whether or not the automobile accident occurred at a time when he or she normally attends classes.

Completed Education means the insured person successfully completed his or her schooling or education program he or she was pursuing (elementary, secondary or post-secondary) or the insured person withdrew from school with no intention of returning.

ELECTION

In some cases, an individual may be eligible for more than one weekly benefit. In these cases, the person must elect which benefit he or she wishes to receive under Section 36 of the *SABS*.

GUIDELINE FOR IDENTIFYING INDIVIDUALS WHO QUALIFY FOR EDUCATION DISABILITY BENEFITS

Commissioner's Guideline No. 4/95

This guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

This guideline is to be considered when determining whether an insured person qualifies for education disability benefits.

For the purposes of the *Statutory Accident Benefits Schedule* (SABS), an individual may qualify for education disability benefits if he or she can be described as:

1. pre-school age at the time of the accident and continues to have a disability which causes the child to miss a year of school, or
2. enrolled on a full-time basis in an elementary education level, or
3. enrolled on a full-time basis in a secondary education level, or
4. enrolled on a full-time basis in a post-secondary education level, or
5. completed school within one year prior to the accident.

DEFINITIONS:

Elementary education level includes kindergarten to grade eight at a public school, separate school or private school of equivalent level, approved by the minister responsible for education or schools in other jurisdictions approved by a comparable authority.

Secondary education level includes grades nine to thirteen or equivalent, at a school that is under the jurisdiction of a secondary school board or a private school of equivalent level, approved by the minister responsible for education or schools in other jurisdictions approved by a comparable authority.

**This guideline applies to Bill 164-Accidents After December 31, 1993 and Before November 1, 1996, as per OIC Bulletin No. A-12/96*

Post-secondary education level	includes programs taken at community colleges, level universities and equivalent institutions approved by the minister responsible for education or programs taken at institutions in other jurisdictions with approval by a comparable authority.

TYPICAL SITUATIONS:

1. PRE-SCHOOL AGE

These individuals are normally children under age five on the date of the accident. They do not qualify for education disability benefits at the time of the automobile accident.

The individual would qualify for the lump-sum benefit at the age at which he or she would have started elementary school, provided the impairment sustained in an automobile accident prevents him or her from successfully completing that year.

2. ELEMENTARY EDUCATION LEVEL

For the purposes of the SABS, an individual is eligible for education disability benefits if he or she is enrolled and attending a school providing education at an elementary level.

An individual is also eligible for education disability benefits if the automobile accident occurred at the time a school providing the education does not normally operate.

3. SECONDARY EDUCATION LEVEL

For the purposes of the SABS, an individual is eligible for education disability benefits if he or she is enrolled and attending a school providing education at a secondary level.

An individual is also eligible for education disability benefits if the automobile accident occurred at the time a school providing the education does not normally operate.

4. POST-SECONDARY EDUCATION LEVEL

For the purposes of the SABS, an individual is eligible for education disability benefits if he or she is accepted or enrolled in a school providing education at a post-secondary level.

An individual is also eligible for education disability benefits if the automobile accident occurred at a time when he or she does not normally attend classes.

A student who is in a co-operative program and working at the time of the accident is also eligible for education disability benefits.

5. Completed school

An individual qualifies for the weekly education disability benefit if he or she completed his or her education within one year prior to an automobile accident and is not employed or in an employment not reflecting his or her education and training.

An individual who withdraws from school also qualifies for the weekly education benefit if the automobile accident occurred within one year of withdrawing from school.

Election

In some cases, an individual may be eligible for another weekly benefit as well as being eligible for the education disability benefit. In these cases, the election under section 61 applies.

GUIDELINE ON THE MANAGEMENT OF CLAIMS INVOLVING WHIPLASH-ASSOCIATED DISORDERS

This guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

This guideline applies to all accidents occurring on or after January 1, 1994, including accidents on or after November 1, 1996 and is intended to help insurers, claimants, and providers understand what is a reasonable medical and rehabilitation expense for a person who has sustained a whiplash injury in an auto accident. The *Statutory Accident Benefits Schedule* requires that insurers pay for all reasonable and necessary medical and rehabilitation expenses incurred by or on behalf of a claimant who sustains an impairment as a result of an auto accident.

BACKGROUND

The Société d'assurance automobile du Québec (SAAQ) is the public auto insurer in the Province of Quebec. The SAAQ sponsored a task force on whiplash-associated disorders (WAD) which submitted a report in early 1995. The Task Force Report makes specific recommendations regarding the prevention, diagnosis and treatment of WAD. Included in the report is a proposal for classifying WAD and patient management guidelines. The *Guideline on the Management of Claims Involving Whiplash-Associated Disorders* is based on the recommendations made by the Quebec Task Force.

For those who would like to review the study, the Task Force Report titled *Redefining "Whiplash" and its Management* was published in the April 15, 1995 edition of Spine. The full report is available directly from the SAAQ.

DEFINITIONS

The Quebec Task Force defined **whiplash** as an acceleration-deceleration mechanism of energy transfer to the neck which may result from rear-end or side impact, predominantly in motor vehicle collisions, but also from diving accidents, and from other mishaps. The energy transfer may result in bony or soft tissue injuries (whiplash injury), which in turn may lead to a wide variety of clinical manifestations (whiplash-associated disorders).

Whiplash-associated disorder (WAD) is the term adopted by the Quebec Task Force to describe the clinical entities associated with the energy transfer and the injury.

WAD Case Management Guide

Insurers should encourage practitioners to use the Quebec Classification of Whiplash-Associated Disorders (found in Chart 1) in their reports.

Chart 2 provides a guide, in the form of a flow chart, to managing WAD cases. Insurers are encouraged to use the chart and accompanying operational definitions. Insurers should be aware that this is only a guide in evaluating the clinical management of their claimants with WAD and only in those cases where no other injury exists. The most important objective is to prevent chronicity. The consensus is that claimants that are disabled for six months or more should be considered chronic.

According to Chart 2, unresolved disability in Grade I WAD cases would undergo a specialized consultation at 3 weeks and a multidisciplinary consultation after 6 weeks. For Grade II and III WAD, specialized consultation for unresolved cases should take place at 6 weeks and multidisciplinary consultation at 12 weeks. Grade I WAD cases with persistent problems should be reassessed in 7 days, and Grade II and III WAD cases, who have not returned to usual activity in 3 weeks, should be reassessed.

Treatment of WAD

The Quebec Task Force found most therapeutic interventions currently used in patients with WAD have not been evaluated in a scientifically rigorous manner. Those treatments that have been evaluated in a scientifically rigorous manner show little evidence of effectiveness. In general, interventions promoting activity such as mobilization, manipulation, and exercises in combination with analgesics or certain anti-inflammatory drugs are effective on a time-limited basis. Insurers should carefully monitor claims where treatment is prolonged and activity is discouraged.

Insurers should be wary of claims where the practitioner is not encouraging early return to usual activities. Immediate return to usual activities is recommended for Grade I WAD with no work restriction. For Grade II and III WAD, return to usual activity as soon as possible should be encouraged, typically in less than 1 week for Grade II WAD. Work modifications may be necessary for Grades II and III, but should be temporary, except for clinical circumstances justified as unusual or for atypical work settings. Work modifications should be reassessed within 3 weeks.

Chart 3 summarizes treatment recommendations made by the Quebec Task Force for WAD patients. Insurers may wish to use the chart as a guide to evaluating treatment programs.

CHART 1

QUEBEC CLASSIFICATION OF WHIPLASH-ASSOCIATED DISORDERS

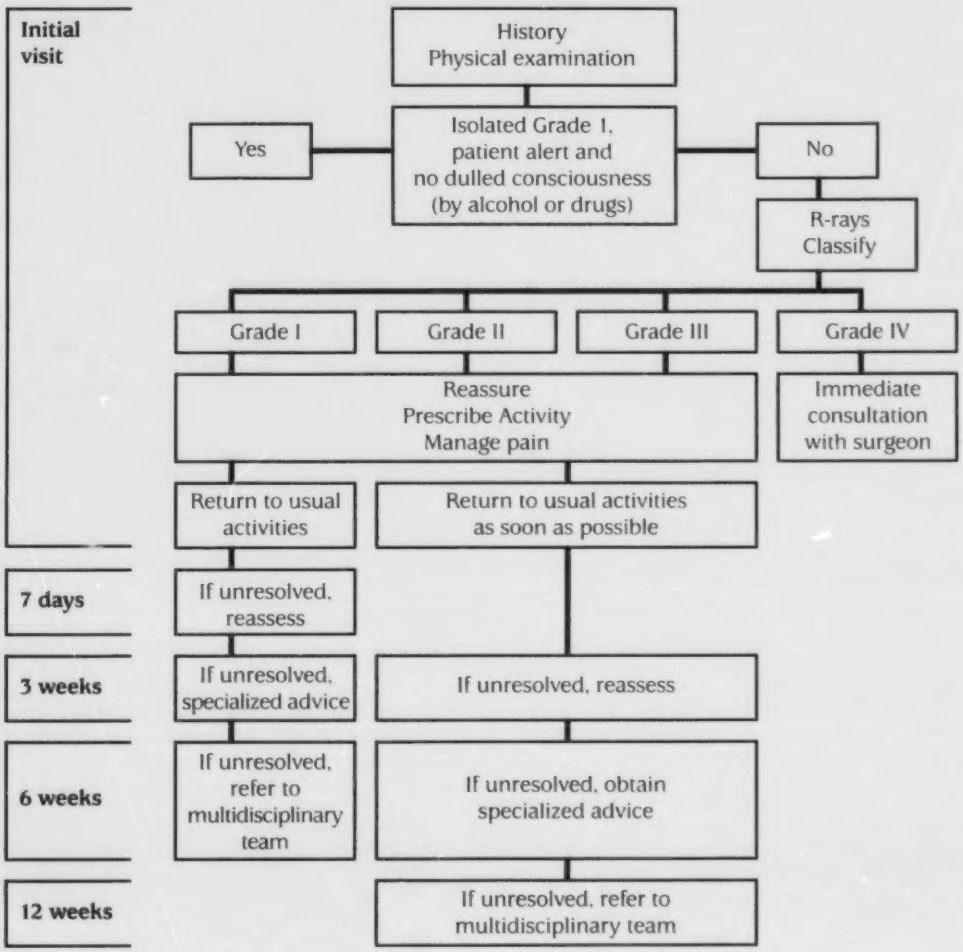
Grade	Clinical Presentation
I	Neck complaint of pain, stiffness or tenderness only No physical sign(s)
II	Neck complaint **AND** Musculoskeletal sign(s) including decreased range of motion and point tenderness
III	Neck complaint **AND** Neurological sign(s) including decreased or absent deep tendon reflexes, weakness and sensory deficits
IV[1]	Neck complaint **AND** Fracture or dislocation

Symptoms and disorders that can be manifest in all grades include deafness, dizziness, tinnitus, headache, memory loss, dysphagia, and temporo-mandibular joint pain.

[1] Grade IV injuries are not considered WAD.

CHART 2

WAD CASE MANAGEMENT GUIDE



OPERATIONAL DEFINITIONS

Isolated	Not associated with other injuries.
Multidisciplinary team	Health professionals with in-depth formal training in musculoskeletal disorder, psychosocial assessment, and other specialties.
Prescribe activity	Interventions should focus on promoting activity. Range of motion exercises should be implemented. Techniques that promote mobility of the cervical spine can be used but should be applied by qualified personnel. Interventions that impede active mobilization of the neck are not indicated.
Reassure	Patients should be advised that most WAD are benign and self-limiting, and they should be encouraged to resume usual activities of life as soon as possible.
Return to usual activities	Patients should be advised to resume their activities of daily living, as soon as possible (usually immediately for Grade I). It should be explained to patients that usual activities may be temporarily painful but not harmful in WAD.
Specialized advice	Consultations with a health professional with in-depth formal training in managing WAD.
Unresolved	Unable to resume usual activities. A patient who still has residual pain or limitation of range of motion but who is able to resume work and other usual activities is considered to have resolved WAD.

CHART 3

TREATMENT GUIDE FOR WAD

Treatment	Recommendation
IMMOBILIZATION	
Collars:	Collars should not be prescribed for Grade I WAD. If prescribed for Grade II or III, they should be restricted to no more than 72 hours as they may promote inactivity and delay recovery.
Prescribed rest:	Rest should not be prescribed for WAD I. Rest for more than 4 days should not be prescribed for WAD II. Prolonged rest can be detrimental to recovery.
Cervical pillows:	Cervical pillows are not required.
ACTIVATION	
Manipulation:	A short-term regimen of manipulation can be used for WAD. This technique should be restricted to qualified practitioners.
Mobilization:	A regimen of mobilization may be used for WAD.
Exercise:	Range of motion exercises should be implemented immediately, in combination if necessary, with intermittent rest when pain is severe. Clinical judgement is crucial if symptoms are aggravated.
Posture advice:	Postural advice can be given in combination with activation in WAD.
Spray and stretch:	Spray and stretch is not recommended.
Traction:	A regimen of traction can be used in combination with other mobilizing interventions in WAD.

Treatment	Recommendation
PASSIVE MODALITIES/ELECTROTHERAPIES	
Heat, ice, massage, TENS[1], PEMT[2], electrical stimulation, ultrasound, laser, short-wave diathermy:	PEMT is not recommended for Grade I WAD because it involves wearing a soft collar for 8hr/day for 12 weeks. The other professionally administered passive modalities/electrotherapies are optional adjuncts for Grades II and III WAD during the first 3 weeks to activating interventions with emphasis on return as soon as possible to usual activity.
SURGICAL TREATMENT	There are no indications for surgical intervention in Grade I and II WAD. Surgery is to be restricted to the rare Grade III WAD with persistent arm pain that does not respond to conservative management or with rapidly progressing neurologic deficit.
INJECTIONS	
Steroid injections:	Intra-articular steroid injection cannot be recommended for WAD. There is no reason for a practitioner to prescribe any of these treatments. Practitioners should recommend against the magnetic necklace. Epidural steroid injections should not be used for Grade I or II WAD. Occasionally, Grade III WAD with unresolved radicular pain of less than 1 month might benefit from epidural steroid injections. There is no indication for steroid trigger point injection in the acute phase (first 3 weeks). Because harmful side effects of repeated steroid use have been reported, steroid trigger point injections should not be used unless their benefit in WAD is shown.
Sterile water injections:	Sterile water subcutaneous trigger point injections can be used for Grade II WAD where trigger points are present as an optional adjunct to activating interventions with emphasis on return to usual activities.

[1] Transcutaneous electrical nerve stimulation

[2] Pulsed electromagnetic treatment

Treatment	Recommendation
PHARMACOLOGY	No medication should be prescribed for Grade I WAD. Non-narcotic analgesics and NSAIDs[1] can be used to alleviate pain for short-term in Grades II and III WAD. Their use should not be continued for more than 3 weeks. Narcotic analgesics should not be prescribed for Grade I and II WAD. Occasionally, they may be prescribed for pain relief in acute severe Grade III, but only for a limited period of time. Muscle relaxants should not generally be used in the acute phase of WAD. The psychopharmacologic drugs are not recommended for use on a general basis in WAD but they may be used occasionally for symptoms such as insomnia or tension, as an adjunct to activating interventions during the first 3 months. For chronic pain in WAD (over 3 months duration), the minor tranquillizers and antidepressants may be used.
MISCELLANEOUS INTERVENTIONS (FORMALLY PRESCRIBED)	
Prescribed function, Neck school, work alteration, relaxation techniques, acupuncture	Prescribed function, i.e., **immediate** return to usual activity is recommended for Grade I WAD. Neck school, work alteration, and relaxation techniques are not indicated for Grade I WAD. For Grades II and III, prescribed function, i.e., return to usual activity, is encouraged as soon as possible. Neck school, temporary work alteration, relaxation techniques, and acupuncture are optional adjuncts for symptom durations of more than 3 weeks in Grades II and III.
OTHER INTERVENTIONS (NOT FORMALLY PRESCRIBED)	
Magnetic necklace, relaxation techniques, topicals, herbal and homeopathic remedies, over the counter, medication, reflexology	There is no reason for a practitioner to prescribe any of these treatments. Practitioners should recommend against the magnetic necklace.

[1] nonsteroidal anti-inflammatory drugs such as aspirin or acetaminophen

OPTIONAL INDEXATION BENEFIT GUIDELINES

These guidelines are issued pursuant to section 268.3 of the *Insurance Act* and apply to accidents occurring on or after November 1, 1996.

PURPOSE

The purpose of the *Optional Indexation Benefit Guidelines* is to set out the procedures and formulas for indexation as referred to in section 29 of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996.*

GENERAL APPLICATION

These guidelines apply to named insured persons who have purchased the optional indexation benefit, their spouse, dependants and persons specified as drivers under the policy.

Indexation applies to the following benefits and monetary limits:

1) the weekly amount of any income replacement benefit
2) the weekly amount of any non-earner benefit
3) the weekly monetary limits applicable to income replacement benefits
4) the weekly monetary limits applicable to caregiver benefits
5) the monthly attendant care monetary limits
6) the outstanding balance of medical and rehabilitation benefits available
7) the outstanding balance of attendant care benefits available
8) the outstanding balance of medical, rehabilitation and attendant care benefits available to persons who have access to the optional increased medical, rehabilitation and attendant care benefit

Benefit amounts and monetary limits are indexed on January 1 of each year immediately following the accident.

INDEXATION PERCENTAGE

The indexation percentage is the percentage change in the Consumer Price Index for Canada (All Items), as published by Statistics Canada under the authority of the Statistics Act (Canada), for the period from September in the year immediately preceding the previous year to September of the previous year.

The indexation percentage for January 1, 1997 will be published by the Ontario Insurance Commission once it is available.

INDEXATION OF INCOME REPLACEMENT BENEFIT (IRB) AND NON-EARNER BENEFIT

The weekly amount of a person's income replacement benefit (80 per cent of net income) and the applicable monetary limit ($400, $600, $800 or $1,000, depending on whether optional IRBs were purchased), are adjusted using the indexation percentage on January 1 of the year immediately after the accident. In each subsequent year, the weekly benefit and limit from the previous year are adjusted. Indexation is applied before taking into account any collateral source income.

Similarly, with respect to the non-earner benefit, the benefit limits ($185 and $320, as applicable to the person) are adjusted using the indexation percentage on January 1 of the year immediately after the accident. In each subsequent year, the previous year's limit is adjusted. Indexation is applied before taking into account any collateral source income.

INDEXATION OF WEEKLY LIMITS FOR CAREGIVER BENEFIT AND MONTHLY LIMITS FOR ATTENDANT CARE BENEFIT

The indexation percentage is applied to the monetary limits for the caregiver benefit and the attendant care benefit on January 1 of the year immediately following the accident. In each subsequent year, the limits from the previous year are adjusted.

Indexation shall be performed in accordance with the following formula:

A=B x (1+(C÷100)) where,

A=the new amount (i.e. the new monetary limit or the new weekly benefit)
B=the previous year's amount
C=the indexation percentage

INDEXATION OF MEDICAL, REHABILITATION AND ATTENDANT CARE LIMITS

The outstanding balance with respect to medical and rehabilitation benefits and the outstanding balance with respect to the attendant care benefit are indexed on January 1 of each year immediately after the accident. Indexation of these limits is performed using a declining balance method.

Incurred medical, rehabilitation and attendant care expenses up to December 31 of the year are subtracted from the insured person's limits for that year, for each benefit. The indexation percentage is applied to the outstanding balance (i.e. the unused portions). The indexed amounts become the insured person's new monetary limits for the year. Indexation using the declining balance method applies to each of the following:

1) the combined medical and rehabilitation monetary limit,
2) the attendant care monetary limit, and
3) the combined medical, rehabilitation and attendant care monetary limit, if the optional medical, rehabilitation and attendant care benefit was purchased.

Indexation using the declining balance method shall be applied in accordance with the following formula:

A=(B-C)x(1+(D÷100)) where,

A= the new monetary limit (i.e. new medical and rehabilitation monetary limit, new attendant care monetary limit or new combined monetary limit available to the person)
B= the previous year's monetary limit
C= the sum of all incurred expenses for the previous year (i.e. sum of medical expenses, rehabilitation expenses or attendant care expenses)
D= the indexation percentage

NOTICE OF OUTSTANDING BALANCE

Upon the request of the insured person, insurance companies are to provide a notice stating the outstanding balance, as indexed, of the medical and rehabilitation benefits and the attendant care benefit and the outstanding balance of the combined benefits, if applicable, as of January 1 of the year.

TRANSPORTATION EXPENSE GUIDELINES

These guidelines are issued pursuant to section 268.3 of the *Insurance Act* and apply to accidents occurring on or after November 1, 1996.

PURPOSE

The purpose of the *Transportation Expense Guidelines* is to provide a framework for insurers and insured persons to determine the circumstances under which expenses related to transportation of an insured person to and from treatment sessions must be paid by an insurer. The guidelines set out authorized expenses and applicable rates for the purpose of subsections 14(5), 15(11) and 24(3) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996.*

AUTHORIZED EXPENSES

The insurer is liable to pay for all reasonable and necessary transportation expenses for each trip that the insured person makes to and from treatment sessions, counselling sessions, training sessions, examinations and assessments. The insurer is also liable to pay for all reasonable and necessary transportation expenses of the insured person's aide or attendant. Transportation expenses are calculated based on the most direct route. Transportation expenses include parking fees incurred.

The mode of transportation selected should be the most economical, practical for the distance to be travelled and appropriate under the specific circumstances.

USE OF AUTOMOBILES

The insurer is liable to pay a mileage expense for transportation of the insured person and their aide or attendant, to and from treatment sessions, counselling sessions, training sessions, examinations and assessments using the insured person's automobile, excluding the first 50 kilometres of each trip. This applies to minors who are driven to treatment sessions, examinations or assessments.

For the purpose of these guidelines, the "insured person's automobile" includes any automobile owned or leased by the insured person or any other automobile to which the insured person has access.

The rate that is to be used to calculate transportation expenses for the use of the insured person's automobile is twenty two cents per kilometre (22¢/km) travelled.

USE OF TAXIS

The insurer is liable to pay for reasonable and necessary taxi fare incurred by an insured person and their aide or attendant provided that,

- the insured person does not own or have access to an automobile; or
- the insured person is unable to operate an automobile; or
- it is reasonable and practical in the circumstances to take a taxi.

OTHER MODES OF TRANSPORTATION

Insurers are liable to pay for reasonable and necessary expenses for other modes of transportation where circumstances warrant. Before an insured person incurs expenses for air, rail and bus transportation services, he or she should discuss the matter with their insurer.

TRANSPORTATION EXPENSE GUIDELINES

These guidelines are issued pursuant to subsections 14(5), 15(11) and 24(3) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996* (SABS) and section 268.3 of the *Insurance Act*. These guidelines replace Guideline No. 6/96 effective March 31, 2001.

PURPOSE

The purpose of the *Transportation Expense Guidelines* is to provide a framework for insurers and insured persons to determine the circumstances under which expenses related to transportation of an insured person to and from treatment sessions must be paid by an insurer. The guidelines set out authorized expenses and applicable rates for the purpose of subsections 14(5), 15(11) and 24(3) of the *Statutory Accident Benefits Schedule - Accidents on or After November 1, 1996*.

AUTHORIZED EXPENSES

The insurer is liable to pay for all reasonable and necessary transportation expenses for each trip that the insured person makes to and from treatment sessions, counselling sessions, training sessions, examinations and assessments. The insurer is also liable to pay for all reasonable and necessary transportation expenses of the insured person's aide or attendant. Transportation expenses are calculated based on the most direct route. Transportation expenses include parking fees incurred.

The mode of transportation selected should be the most economical, practical for the distance to be travelled and appropriate under the specific circumstances.

USE OF AUTOMOBILES

The insurer is liable to pay a mileage expense for transportation of the insured person and their aide or attendant, to and from treatment sessions, counselling sessions, training sessions, examinations and assessments using the insured person's automobile, excluding the first 50 kilometres of each round-trip. The 50 kilometre "deductible" is only applicable once in any round-trip. This applies to minors who are driven to treatment sessions, examinations or assessments.

For the purpose of these guidelines, the "insured person's automobile" includes any automobile owned or leased by the insured person or any other automobile to which the insured person has access.

The rate that is to be used to calculate transportation expenses for the use of the insured person's automobile is 27.5¢ per kilometre (27.5¢/km) travelled.

USE OF TAXIS

The insurer is liable to pay for reasonable and necessary taxi fare incurred by an insured person and their aide or attendant provided that,

- the insured person does not own or have access to an automobile; or
- the insured person is unable to operate an automobile; or
- it is reasonable and practical in the circumstances to take a taxi.

OTHER MODES OF TRANSPORTATION

Insurers are liable to pay for reasonable and necessary expenses for other modes of transportation where circumstances warrant. Before an insured person incurs expenses for air, rail and bus transportation services, he or she should discuss the matter with their insurer.

GUIDELINE RESPECTING CONFLICT OF INTEREST IN THE PROVISION OF MEDICAL AND REHABILITATION SERVICES

[This Guideline is issued pursuant to section 268.3 of the Insurance Act, R.S.O. 1990, c.I.8, as amended.]

THE TREATMENT PLAN

The *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996* (SABS) sets out a new procedure for insured persons to follow when applying for medical and rehabilitation benefits.

The insured person must submit a Treatment Plan completed by a member of a health profession before incurring expenses for medical or rehabilitation services. For the purposes of the SABS, the Treatment Plan form is the application form for medical and rehabilitation benefits. The Commissioner has approved OCF-18/59 as the Treatment Plan form to be used under the SABS.

When an insured person applies for medical and rehabilitation benefits, the insurer will review the Treatment Plan and decide what goods and services it is prepared to pay for. However, an insurer may waive the requirement for a Treatment Plan where the insurer has agreed to pay for the goods or services.

In addition, an insurer is required to pay for chiropractic or physiotherapy treatment within the first six weeks following the accident, pending the outcome of any dispute over such services. The insured person can attend up to 15 treatments, during the initial six week period, provided that the insured person has submitted a Treatment Plan to the insurer before commencing treatment.

OBLIGATION TO DISCLOSE CONFLICTS OF INTEREST

There are obligations in respect to conflicts of interest imposed on three different groups: health professionals; lawyers, or other persons representing claimants; and insurers.

The obligations with respect to conflicts of interest for health professionals arise in the preparation and signing of the Treatment Plan for the claimant. The obligations are as follows:

- The health professional must disclose any conflict of interest he or she may have in relation to the treatment plan.

- In cases where another person has referred the insured to the persons who will be providing the goods and services under the plan, the health professional must make reasonable efforts to determine whether the person who made the referral has a conflict of interest.

- If the other person who referred the insured person to the treating facility has a conflict of interest in relation to the treatment plan, the health professional must disclose the conflict of interest in the treatment plan.

The OCF-18/59, the form to be used in the preparation of a treatment plan, includes a disclosure statement to be signed by the health professional; this satisfies the requirements.

The obligations of a lawyer or other representative of the claimant is to disclose any conflict of interest to the insurer at the time the application for benefits is submitted.

The insurer is required to disclose any conflict of interest to the claimant within 14 days of receiving the application, unless it has already rejected the application because of a conflict of interest disclosed by the health professional or the claimant's lawyer or other representative.

CONFLICT OF INTEREST DEFINED

Section 38(24) of the SABS defines "conflict of interest":

(a) A person has a conflict of interest relating to a treatment plan if,

(i) the person or a member of the person's family may receive a financial benefit, directly or indirectly, as a result of the provision, by a member of the person's family or another person, of goods or services contemplated by the treatment plan, and

(ii) the person who may receive the financial benefit is not the employee of the person who will provide the goods or services and does not have a contract with the person who will provide the goods or services under which goods or services of that kind are provided; and

(b) An insurer has a conflict of interest relating to goods or services to which an insured person is referred by the insurer if the insurer may receive a financial benefit, directly or indirectly, as a result of the provision of the goods or services.

MEMBER OF A PERSON'S FAMILY DEFINED

Section 38(25) of the SABS defines "member of a person's family":

"member of the person's family" means, in the case of a person who is not a corporation, any other person connected with the person by blood relationship, marriage or adoption, and

(a) persons are connected by blood relationship if one is the child or other descendent of the other or one is the brother or sister of the other,

(b) persons are connected by marriage if one is the spouse of the other or of a person who is connected by blood relationship to the other, and

(c) persons are connected by adoption if one has been adopted, either legally or in fact, as the child of the other or as the child of a person who is connected by blood relationship (otherwise than as a brother or sister) to the other.

COMMENTARY

PURPOSE OF DISCLOSURE

The purpose of this provision is to identify situations where referrals for profit are likely to exist and where a party is in a position to unduly influence the course of treatment to their own pecuniary advantage.

Where a conflict of interest exists, the possibility arises that the interests of the insured person might not always be paramount. Therefore, where a conflict of interest does exist, the party having the conflict is required to disclose it. Some typical situations that arise are set out below as guidance:

SELF-REFERRALS

- The conflict of interest provisions indicate that the person who receives a financial benefit would have to profit from services provided by another person. Therefore, if the health professional who prepares the Treatment Plan is the person who will treat the insured person, no conflict of interest exists.

REFERRALS WITHIN A FACILITY

- The conflict of interest provisions are also not intended to extend to co-workers within a facility. If the person completing the Treatment Plan is employed by or is under contract with the same facility that provides the treatment, no conflict of interest exists.

REFERRALS FOR PROFIT

- If the person who prepares the Treatment Plan receives a financial benefit for referring the insured person to a treatment facility, a conflict of interest exists. However, no conflict of interest exists if the person who prepares the Treatment Plan is an employee of the same facility that will be carrying out the treatment.

- If the insured person is referred to a treatment facility by another person who will receive a financial benefit, a conflict of interest exists. However, no conflict of interest exists if the person making the referral is an employee of the same facility.

FINANCIAL BENEFIT

The regulation provides that a conflict of interest exists if the health professional, lawyer or representative of the insured, or a member of their family, or the insurance company receives a financial benefit, either directly or indirectly, as a result of a referral.

A financial benefit can consist of any thing of value. For the purposes of this regulation, the following types of arrangements would result in a financial benefit being received:

- any benefit received by the person for the referral in the form of a referral fee, commission, rebate, or gift;

- the sharing of profits;

- the expectation of cross referral;

- obtaining or providing goods or services at prices that are substantially higher or lower than the fair market value;

- an agreement between an insurance company and a provider to limit the quantity of services to be provided to insureds who are referred to the provider by the company.

The above examples are illustrative and are not an exhaustive list of the types of arrangements that could result in a financial benefit being received by a health provider, the insured person's lawyer or representative, or the insurance company.

DISCLOSURE BY A HEALTH PROFESSIONAL

The regulation places the onus on the health professional completing the Treatment Plan form to make inquiries and disclose any conflicts of interest on the form. The regulation does not require the health professional to provide any other statement respecting conflicts of interest. In particular, the health professional is not required to provide an insurance company with documented proof that no conflict of interest exists.

DISCLOSURE BY THE INSURANCE COMPANY WHEN THE TREATMENT PLAN IS WAIVED

If the insurance company waives the requirement for a Treatment Plan, the company has an obligation to notify the insured in writing of any conflict of interest that the company has with respect to the goods or services provided to the insured.

WHEN A CONFLICT OF INTEREST IS DISCLOSED

If a conflict of interest is disclosed by the health professional who prepared the Treatment Plan, or by the insured person's lawyer or representative, the insurance company may refuse the Treatment Plan, provided that it notifies the insured person within 14 days of receiving the plan. In this case, the insured person would have to submit a new Treatment Plan that recommends providers who did not have a conflict of interest.

The conflict of interest provisions are not intended to prohibit treatment when a conflict exists but rather require disclosure of such situations. It is intended to eliminate the ability of one of the parties to influence the course of treatment for their pecuniary advantage. Therefore, the insurance company may approve a Treatment Plan despite the existence of a conflict and should exercise discretion before denying plans based on a conflict of interest.

WHEN A CONFLICT OF INTEREST IS NOT DISCLOSED, BUT IS DISCOVERED AFTER THE COMMENCEMENT OF TREATMENT

If an insurance company discovers that a conflict of interest exists with respect to goods or services provided under a Treatment Plan, the company may give the insured person notice that the insured has 14 days to amend the Treatment Plan to remove the conflict of interest. This would mean that the insured person would have to be referred to another health provider who did not have a conflict of interest. The insured would receive goods or services from the new health provider.

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PRACTICE NOTE
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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

USING MEDICAL EVIDENCE TO SUPPORT YOUR CLAIM FOR ACCIDENT BENEDITS

Claimants are required to prove and support their claim for accident benefits with appropriate medical evidence.

The type of medical documentation you will need to support your claim for accident benefits depends upon when your accident occurred. Changes to the *Statutory Accident Benefits Schedule ("SABS")*, effective November 1, 1996 (Bill 59), include changes to the procedures and documents used to claim benefits. To find out exactly what procedures to use in your case, you should refer to the version of the *SABS* in effect at the time your accident occurred.

No matter when your accident occurred, medical documentation will generally be required in three situations: starting your claim; continuing your claim and disputing when your claim ends.

This note explains the general procedures for providing the information required to support your claim for benefits.

WHAT MEDICAL EVIDENCE DO I NEED TO START MY CLAIM?

If your accident occurred before November 1, 1996, you will need to submit a **Health Practitioner's Certificate** to the insurer.

If your accident occurred after November 1, 1996, and you are claiming weekly benefits, you will need a **Disability Certificate.**

These certificates are part of the Application for Accident Benefits package the insurer sends you. These certificates must be filled out by a qualified health practitioner. This is usually a medical doctor, chiropractor, dentist, optometrist, psychologist or physiotherapist. The insurer should pay your health practitioner directly for filling out the certificate. These certificates provide the insurer with information on the cause and nature of your injury and whether your injuries prevent you from doing your regular activities.

DO I NEED A SPECIAL CERTIFICATE BEFORE I CAN GET TREATMENT?

If your accident occurred before November 1, 1996, you are not required to submit a special form before you receive medical treatment. However, an insurer may request a **Health Practitioner's Certificate** after you have started treatment, to ensure it is reasonable and necessary.

The insurer may also ask you to provide a certificate for any medical or rehabilitation service or item which you have paid for, or intend to pay for, before they will reimburse you.

If your accident occurred after November 1, 1996, your insurance company will include a **Treatment Plan** form in your Application for Accident Benefits. You must provide your insurer with a completed treatment plan signed by your health practitioner before starting any treatment or purchasing any rehabilitation goods or services. In some cases, your insurer may agree to pay for an expense that is not provided for in a treatment plan where the insurer is satisfied that the expense is reasonable and necessary. You should discuss this with your insurer directly. The **Treatment Plan** form asks for information on the types of goods and services you need, how long treatment is expected to continue, who will treat you and what the goods or services will cost. The insurance company will respond to each item listed on the **Treatment Plan**.

WHAT IS AN INSURER'S MEDICAL EXAMINATION?

In order to assist in determining whether your claim for weekly benefits should be paid, or whether your claim for medical or rehabilitation benefits is reasonable or necessary, the insurer may ask you to attend a medical examination at their cost.

The *SABS* provides that your insurance company can ask you to be examined by one or more health professionals – chosen by the insurer – for an opinion about your claim. The insurer is allowed to do so "as often as is reasonably necessary."

If you are asked to attend an insurer's medical examination, remember:

- The insurer's medical examination usually provides an assessment of your current medical condition and treatment needs.
- If you fail to attend the examination, depending on the version of the *SABS* in effect, and the type of benefits involved, the insurance company may terminate your benefits until you attend. In some cases, you cannot commence mediation if you have not made yourself reasonably available for an insurer's medical examination.
- If you cannot attend on the date scheduled, you should notify your insurance company right away, because the company will still have to pay the health professional if you do not show up. Your insurer may then claim you are responsible for these expenses.

The insurance company is required to:

- Consider your convenience and particular situation when scheduling medical appointments, and give you reasonable notice of the appointment.
- Provide copies of the examination report to you and/or your health professional.

WHAT IF I WANT ANOTHER OPINION?

If you want a medical report from your own health professional to respond to the medical report obtained by the insurer, you are responsible for paying for this report. In some cases, your insurance company may pay your expenses.

DESIGNATED ASSESSMENT CENTRES

Designated Assessment Centres (DACs) have been established to provide independent assessments of your disability or of your medical, rehabilitation and attendant care needs. DACs can conduct assessments at the request of either the claimant or the insurance company. They provide a speedy, neutral way to evaluate medical issues.

You may be required to attend a DAC if your accident occurred on or after January 1, 1994. Depending on the version of the *SABS* in effect at the time of your accident, the centres may also assess your earning capacity, and the types of employment that might be available to you if you suffer from long-term physical or psychological problems, and whether your injuries are catastrophic.

The DAC assessment usually involves a medical examination. The assessment can take less than a day or as long as two weeks to complete.

If you request a DAC assessment, or you are required by the insurer to go to one, then you

must provide the DAC with all relevant medical documentation. Make sure the health practitioners who have treated you provide their reports and records to the DAC directly.

The *Statutory Accident Benefits Schedule* sets out the conditions under which you may be required to be assessed at a DAC. These conditions vary depending on the date of the accident, so it is important to refer to the version of the *SABS* in effect at that date.

For accidents occurring before November 1, 1996, you may be required to undergo a DAC assessment:

- if you claim medical expenses incurred more than 8 weeks after the accident; or if the insurance company has already paid out more than $2,000 in medical benefits;
- if you apply for social rehabilitation or vocational rehabilitation expenses, or for attendant care benefits; and
- if you reject the insurance company's assessment of post-accident earning capacity (for claims over two years in length).

For accidents occurring after November 1, 1996, you may be required to undergo a DAC assessment:

- if goods and services are recommended in a treatment plan for which an insurer will not pay;
- if you apply for attendant care benefits; or
- if you apply for a catastrophic impairment determination.

Is a DAC required when the insurer stops paying weekly benefits?

For all accidents occurring on or after January 1, 1994, it is up to you to request a DAC assessment when your insurer decides to stop paying weekly benefits. Your request must be in writing to your insurance company.

Remember, if you request a DAC assessment within 14 days of when you were first told that the insurer will stop the benefit, the weekly benefit will continue to the date of the DAC assessment.

The insurer will pay for the DAC assessment. However, if you fail to attend without reasonable excuse:

- the insurer may ask you to pay the fee charged by the DAC; and
- you may not be permitted to go to mediation or arbitration.

If you can't go to a DAC assessment that has been scheduled, notify the DAC and the insurer right away.

If you have a dispute with an insurer, an insurer's medical examination and a DAC report as well as your own health practitioner's certificates can be used as evidence in mediation, neutral evaluation and arbitration.

This is a brief summary of a complex topic. Please refer to the applicable version of the *Statutory Accident Benefits Schedule* for more precise information.

For more information, see **Practice Note 4**, "Exchange of Documents", which describes the medical documents required for an arbitration hearing.

How do I get more information?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332
- If your question relates to DACs, call (416) 590-7137

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Financial Services Commission of Ontario
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PRACTICE NOTE
NOTE PRATIQUE
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Dispute Resolution Group / Groupe de règlement des différends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

REACHING A SETTLEMENT WITHIN THE DISPUTE RESOLUTION PROCESS

WHAT IS A SETTLEMENT?

A settlement is an agreement between an insurance company and an insured person that finally ends a dispute about the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule ("SABS")*. You can settle one or more issues while others remain in dispute.

WHAT IS A RELEASE?

When you reach a settlement, you may be asked to sign a release form. The release is an agreement with the insurance company that in exchange for the agreed-upon amount you will not make any further claims concerning the disputes that are being settled. Once you sign the release, and two business days have passed, you have no further right to re-open the issue.

WRITTEN NOTICE

Your insurance company must provide you with the following before you enter into an agreement that finally ends your claim or dispute about entitlement to one or more benefits:

- A description of the benefits that are available to you under the *SABS* and any other benefits that may be available under your specific insurance contract;
- A description of the impact of the settlement on all of these benefits, including a statement explaining that the settlement limits the right to mediate, litigate, arbitrate, appeal, or in any way vary the terms of the settlement;
- A statement telling you that you have two business days after reaching the agreement to change your mind and deliver a written notice to the insurance company cancelling the settlement; and
- A statement of the tax implications of the settlement, if any.

CAN I CHANGE MY MIND?

You have two business days to change your mind after agreeing to a settlement. You must tell the insurance company in writing that you wish to do so, within two business days. After the two days, the settlement is binding on you and the insurance company.

OBLIGATIONS

Both sides in the dispute are required to live up to the terms of the settlement. The agreement can be enforced through the courts.

DOES THE COMMISSION HAVE ANY ROLE IN NEGOTIATING SETTLEMENTS?

Mediators help the parties negotiate terms of settlement. Settlement is also discussed where the parties are proceeding to a neutral evaluation, or at an arbitration pre-hearing discussion. Parties may reach a settlement at any time during arbitration. However, Commission mediators, neutral evaluators and arbitrators are not involved in preparing and signing releases or ensuring that the terms of the settlement are followed.

WHAT IF I WANT A LEGAL OPINION?

You do not need a lawyer to negotiate a settlement, but in many circumstances a lawyer's advice on settlement terms can be helpful. If you have any concerns about signing a release, get legal advice.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

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PRACTICE NOTE
NOTE PRATIQUE
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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

PARTICIPATION AND REPRESENTATION AT DISPUTE RESOLUTION ("AUTHORITY TO BIND")

Anyone representing an insurance company or an insured person at mediation, neutral evaluation, or arbitration will be discussing and negotiating agreements and settlements regarding accident benefit disputes. It is essential that people claiming benefits participate in mediation, neutral evaluation or arbitration to hear and discuss settlement offers and give instructions to any representative.

A representative must be able to speak to and negotiate on all issues in dispute. The mediator, neutral evaluator or adjudicator may request written or verbal confirmation that a representative is authorized to discuss the dispute with the Commission, to negotiate, and to enter into an agreement or settlement of any and all issues in dispute. Appointing a representative does not relieve any party of their obligation to participate in the dispute resolution process, except in extenuating circumstances (for example, confinement in a hospital).

A lawyer or an employee representing an insurance company must have the authority to change the company's position based on the evidence presented by the insured at a mediation, neutral evaluation or arbitration. In the case where an insurer's representative has limited authority to enter into an agreement or settlement, an officer of the company **with the requisite authority** must attend or be available by telephone for the duration of the proceeding.

WHAT HAPPENS IF THERE IS NO AUTHORITY TO BIND?

If a party is unable to attend (for example, confinement to hospital), the mediator, neutral evaluator or adjudicator can adjourn a proceeding, with or without conditions, if the representative is not authorized to bind that party to an agreement. The adjournment can be on whatever terms the mediator, neutral evaluator or adjudicator considers appropriate.

An adjudicator has authority to make an interim order of expenses, subject to such terms and conditions as may be established by the adjudicator, should a representative attend without full authority.

WHY IS AUTHORITY TO BIND SO IMPORTANT?

If the representatives do not have authority to bind, a settlement discussion can break down into a series of statements like "I'll have to check that with my client." This can lead to drawn-out, fruitless discussions that waste the time of everyone involved.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

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PRACTICE NOTE
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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

EXCHANGE OF DOCUMENTS

This Practice Note outlines the role and the need for early disclosure of supporting documents in the Commission's dispute resolution process. The note offers general guidelines as to the type of documents that may be relied upon to support a claim, and when they should be gathered and exchanged with the other party. In certain cases, documents relating to a period more than one year prior to the accident may be relevant and ought to be produced.

A. DOCUMENTS

Documents that may assist to resolve a dispute vary with the issues in dispute, but can include the following:

1. **Where disability benefits are in dispute:**

- **Clinical notes and records of physicians** who treated the insured person during the year leading up to the accident and after the accident.
- **Ambulance call reports** if the insured person was transported from the accident by ambulance.
- **Hospital records** if the insured person has received treatment at a hospital in the year before the accident or after the accident.
- **Records of the Workplace Safety & Insurance Board (formerly the Workers' Compensation Board)**, if the insured person was receiving workers' benefits at the time of the accident or in the preceding year.
- **Reports and clinical notes of any medical examination of the insured person that was requested by the insurance company** under the *Statutory Accident Benefits Schedule.*
- Any **report of a Designated Assessment Centre (DAC)** that conducted an assessment of the insured person under the *Statutory Accident Benefits Schedule.*
- **Medical reports** in the possession of the insurance company, such as those prepared by the insured person's treating physicians.
- **An OHIP statement** listing the physicians who have treated the insured person in the year before the accident and after the accident, if it is unclear who has treated the insured person.
- **Surveillance or investigative evidence** if a party intends to rely on any portion. The party must provide particulars of the names and qualifications of any person who took such evidence, including the dates, times and places where any surveillance or investigation was undertaken. The party must provide copies of all surveillance evidence taken or prepared by anyone in connection with the issues in dispute if the party intends to rely on any portion of the surveillance at the hearing.
- **Certain employment records**, such as a job description.

2. **Where the amount of benefits is in dispute:**

- **Certified income tax returns** from Revenue Canada for the year before the accident, and the year of the accident.

- **Financial statements** for the year before the accident and the year of the accident in the case of self-employed claimants. In certain circumstances, more detailed raw financial documentation may be required such as bank statements and records.

- **Any application for Canada Pension Plan disability benefits** and a copy of the granting letter, if it appears that the insured person has applied for or received these benefits.

- **A copy of any health or disability insurance policy**, if it appears that the insured person had coverage at the time of the accident, and a copy of any application form or granting letter.

- **Certain employment records**, such as payroll records, for the year before the accident.

B. DOCUMENTS IN MEDIATION

It is important that parties start discussions about exchanging documents **BEFORE** applying for mediation. Parties should immediately begin to collect material from sources, such as doctors, employers, or accountants. Producing documents and providing them to both the other party and the mediator at an early stage, greatly improves the chances for a successful mediation. Recent amendments to the *Insurance Act*, include a provision respecting early disclosure of key materials required to discuss the resolution of the issues in dispute. As a result of this amendment, parties should review their file early to determine whether they will require any materials from the other party to discuss settlement, and **request these materials, in writing from the other party, as soon as possible.** Claimants will be required to list available documents to which they intend to refer in mediation as well as existing documents they wish to obtain from other sources, at the time they file their ***Application for Mediation***.

Remember that the request for documents at the mediation stage should be realistic and limited to those items which are critical to settlement discussions. The amount and type of documentation necessary to discuss settlement will vary from case to case. The intent of this provision is to facilitate settlement at this early stage of the dispute resolution process, not to introduce a time consuming and costly process of document exchange.

In the majority of cases the documents necessary to settle disputes at mediation, such as income tax returns, employment records and DAC reports, are readily available. In some instances, documents such as bank statements must be secured at a nominal cost. It is not anticipated that in the majority of cases, historical records such as past medical clinical notes and records and OHIP statements will be necessary to discuss settlement at mediation. Records of this nature are expensive and take a significant amount of time to secure. They are more commonly requested at the arbitration stage of dispute resolution.

If either party objects to providing documents requested by the other, they should immediately communicate their objection and their reasons for objecting in advance of the mediation.

If mediation fails, the **Report of Mediator** will contain a list of materials that were requested by the parties in writing but have not been produced that, in the opinion of the mediator, were required for the purpose of discussing settlement of the issues in dispute at mediation.

The **Report of Mediator** will not necessarily list all of the materials requested by the parties for discussion at mediation.

The failure to produce relevant documentation by a party as outlined in the **Report of Mediator** may delay the commencement of an arbitration or may be considered by an arbitrator at the conclusion of a hearing, when deciding a claim for expenses.

C. DOCUMENTS IN NEUTRAL EVALUATION

Parties wishing to proceed to neutral evaluation within an arbitration proceeding at the Commission, must jointly certify that all the documents listed in the **Report of Mediator** have been

exchanged, and that no other documentation is required for an evaluation of the issues in dispute. The person appointed to conduct the neutral evaluation may request additional information to assist in evaluating the issues in dispute.

If the dispute does not settle as a result of neutral evaluation, the evaluator will prepare a **Report of the Neutral Evaluator** listing any materials he or she requested that were not provided by the parties.

The failure to produce relevant documentation by a party as outlined in the **Report of the Neutral Evaluator** may delay the commencement of an arbitration or may be considered by an arbitrator at the conclusion of an arbitration hearing, when deciding a claim for expenses.

D. DOCUMENTS IN AN ARBITRATION HEARING

Parties to an arbitration should exchange all documents necessary to decide the issues in dispute at the earliest possible stage. Applicants will be required to list key documents in their possession as well as documents they intend to obtain from other sources as part of their ***Application for Arbitration.***

The exchange of documents should be worked out between parties and their representatives as soon as possible, and in any event, well before the pre-hearing discussion.

The parties should contact each other and:

- disclose what documents they intend to use at the hearing;
- arrange to give the documents to the other side;
- request any documents that they think they require from the other side; and
- arrange to share documents obtained from third parties.

As a general rule, the party asking for the document is responsible for paying the cost of getting it. When an insurance company arranges to collect documents directly from a third party, it may require the applicant to authorize the collection beforehand. The company must give copies of any documents it obtains to the applicant, as soon as possible.

Where the parties to the arbitration cannot agree which documents to exchange, the pre-hearing arbitrator will rule on what is required.

Where third parties (like hospitals or doctors) are asked to supply documents, the arbitrator will insist that parties make their own reasonable efforts to obtain the documents from the third party before issuing an order requesting the third party to release the documents. One exception to this practice is a request for information from OHIP where, to speed up the process, an arbitrator will make an order at the parties' request. The pre-hearing arbitrator has the final say on what documents must be produced or exchanged **prior** to the arbitration hearing. The hearing arbitrator has the final say on what documents will be considered **during** the hearing.

Arbitration is designed to be relatively informal and quick. It does not have the broad discovery and disclosure processes of the court system. Parties to an arbitration can participate most effectively by promptly disclosing all relevant documents well before the date of the arbitration pre-hearing discussion.

Failing to produce documents well in advance of a hearing can result in adjournments and delays. Furthermore, if documents are not produced promptly, the hearing arbitrator may refuse to admit the documents into evidence or may draw an adverse inference against the party who failed to produce the document. The hearing arbitrator may also deny expenses to that party or award expenses to the other party.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

MEDIATOR REFERRAL TO PRIVATE NEUTRAL EVALUATION

WHAT IS NEUTRAL EVALUATION?

Neutral evaluation is a process designed to encourage the settlement of disputes in certain types of cases. A neutral evaluator will give you and your insurance company a frank review of both of your positions, as well as an assessment of the probable outcome, or range of outcomes, should the dispute be decided in private arbitration, arbitration at the Commission or in court.

Neutral evaluation provides the parties with an additional opportunity to settle outstanding disputes and avoid adjudication. This step in the dispute resolution process has the potential to save the parties time and the expenses associated with taking the dispute through the full process of arbitration or to court. Under the *Insurance Act*, neutral evaluation takes place after mediation fails and before a case proceeds to arbitration or court.

HOW DO I OBTAIN NEUTRAL EVALUATION?

Neutral evaluation can be obtained privately or at the Commission, as part of the Commission's arbitration process. To obtain neutral evaluation at the Commission you must first apply for arbitration and pay the filing fee. You must indicate on your ***Application for Arbitration*** that you wish to participate in neutral evaluation. If the insurer agrees, the Director of Arbitrations will appoint a neutral evaluator from within the Commission and will suspend the arbitration process until the neutral evaluation has been completed. If your case does not settle at neutral evaluation, your dispute will normally be fast-tracked to an arbitration hearing, bypassing the pre-hearing stage. (See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" for more information on this option.)

If you and your insurer choose private neutral evaluation (under the *Insurance Act*), you must agree upon the choice of the neutral evaluator, negotiate the fee, and determine who will pay. The evaluator must then be appointed by the Commission's Director of Arbitrations. The appointment process is simple. The parties write the Director of Arbitrations providing the name, address and telephone number of the neutral evaluator. You must also include written confirmation that the parties agree to pay for the evaluation and that the neutral evaluator has agreed to conduct the evaluation in accordance with the requirements of the *Insurance Act*. Based on this information, the Director of Arbitrations will appoint this individual as your neutral evaluator and provide him or her with a copy of the **Report of the Mediator** as well as an approved format for the **Report of the Neutral Evaluator.**

The Commission is not responsible for payment of the private evaluator's fees nor does it maintain an approved or recommended list of private neutral evaluators.

If a mediator recommends that you and your insurance company engage in neutral evaluation, your case must proceed through private neutral evaluation that is recognized under the *Insurance Act*. This process must be completed before your dispute can proceed to private arbitration, arbitration at the Commission, or court.

WHEN DOES A MEDIATOR MAKE A REFERRAL TO NEUTRAL EVALUATION?

Mediators consider stringent criteria before recommending a referral to neutral evaluation.

First, the mediator must be of the opinion that the neutral evaluation process will likely result in a settlement of your dispute. This opinion will be based on many factors, including the nature of the dispute, the parties' understanding of their case, their expectations, and their reasonableness.

Second, the mediator will evaluate whether the parties have fully documented their positions. Have they provided disclosure to the other side at mediation or can they realistically exchange the documents required within 30 days of the date of the **Report of the Mediator?**

Third, if both parties agree to proceed to neutral evaluation it will be noted in the **Report of the Mediator**. In this case, a mediator referral is not required. The mediator will outline the features of both private and Commission-delivered neutral evaluation. The parties then may choose the route they will pursue.

Fourth, if mutual consent cannot be reached, but the insured person wishes neutral evaluation, the mediator can consider a referral. Under these circumstances the mediator will outline the features of private neutral evaluation as detailed under the *Insurance Act*.

Fifth, before making the referral to private neutral evaluation, the mediator must ensure that the parties have agreed how they will pay for these services. The parties will have to agree on who will perform the evaluation and obtain the appointment of this person's service by the Director of Arbitrations, as outlined above.

HOW DO I CONTACT THE OFFICE OF THE DIRECTOR OF ARBITRATIONS?

The Director of Arbitrations' office can be contacted at:

Financial Services Commission of Ontario
Dispute Resolution Group
Arbitrations Unit
5160 Yonge Street, 14th Floor
North York ON M2N 6L9
phone (416) 590-7202
fax (416) 590-8462
Toll-Free 1-800-517-2332

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Financial Services Commission of Ontario
Commission des services financiers de l'Ontario

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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

NEUTRAL EVALUATION AT THE FINANCIAL SERVICES COMMISSION OF ONTARIO

WHAT IS NEUTRAL EVALUATION?

Neutral evaluation is a voluntary dispute resolution option within the arbitration process at the Financial Services Commission of Ontario designed to provide the parties, in appropriate cases, with an additional opportunity to settle their disputes. Neutral evaluation has the potential to save both parties the time and expense associated with taking disputes through to a full arbitration hearing.

Neutral evaluation is conducted before a neutral evaluator, who is an arbitrator with the Commission. The neutral evaluator provides an early, authoritative, independent, yet **non- binding opinion** of the probable outcome, or range of outcomes, should the dispute continue to a hearing.

Not all cases are suitable for neutral evaluation. Most arbitration cases at the Commission are scheduled for a pre-hearing discussion prior to a hearing (See **Practice Note 7**, "The Arbitration Pre-hearing Discussion").

Neutral evaluation is **not** a substitute for a pre-hearing discussion. The neutral evaluator will not decide disputes relating to the identification and exchange of documents, make procedural rulings or deal with preliminary issues or requests for interim relief.

WHAT CASES ARE APPROPRIATE FOR NEUTRAL EVALUATION?

For neutral evaluation to be effective, both parties must already have requested, produced and received all documents that are necessary and relevant for a determination of the issues in dispute. The neutral evaluator can only provide an authoritative opinion of the probable outcome of the dispute, if the parties are aware of the pertinent facts of the case. The parties to neutral evaluation ought to have all of the documents they would have during final submissions at the conclusion of a hearing. Therefore, cases where important documentation is not yet available are **not** appropriate for neutral evaluation.

Neutral evaluation is intended to resolve the **entire** dispute between the parties. A neutral evaluation will generally **not** be arranged for only part of the overall dispute.

Cases especially suited for neutral evaluation are those where the facts are not in dispute or the dispute centres on a question of legal interpretation which has been canvassed to some extent by either the Commission or by the courts.

Cases involving allegations of fraud or significant credibility issues are generally less likely to benefit from neutral evaluation. In such cases, the opinion of the neutral evaluator may only succeed in further polarizing the parties thereby reducing the probability of settlement.

How do I obtain neutral evaluation at the Financial Services Commission of Ontario?

Neutral evaluation can be requested by an insured person as part of the ***Application for Arbitration*** **(FORM C)**. Where an insured person has requested neutral evaluation, through the application process, the insurer may consent to neutral evaluation by completing an ***Agreement to Neutral Evaluation at the Commission***, in **FORM D** and filing it by facsimile transmission within 20 days of the receipt of the ***Application for Arbitration***.

The insurer may also initiate neutral evaluation by obtaining the written consent of the Applicant and by completing an ***Agreement to Neutral Evaluation at the Commission***, in **FORM D** and by filing both by facsimile transmission within 20 days of the receipt of the ***Application for Arbitration***.

The Commission will not schedule a neutral evaluation unless both parties agree.

How should I prepare for neutral evaluation?

Parties need not be represented by legal counsel at neutral evaluation. However, legal and factual issues which are evaluated are often complex. Most parties are represented by lawyers during the arbitration process, including neutral evaluation.

A date for neutral evaluation will not be scheduled until the parties file a ***Joint Statement for Neutral Evaluation at the Commission*** **(FORM H)** under **Rule 44** of the Dispute Resolution Practice Code setting out each issue in dispute. In addition, each party must prepare a **case summary** under **Rule 45**, setting out exactly what the party seeks, and an outline of the evidence being relied upon, at least 10 days prior to the date set for the evaluation.

Each party must also provide copies of the relevant and necessary documents which support their case and which the neutral evaluator should read and consider before giving an opinion.

Each party should be completely familiar both with their own case, and the other side's case before attending the neutral evaluation. Neither side calls witnesses at a neutral evaluation. In the exceptional case a party may wish to consider having a key individual, such as a bookkeeper or doctor, attend the neutral evaluation to help the evaluator understand the evidence. To do this, it will be necessary to obtain the written consent from the Office of the Registrar prior to the evaluation.

Do I need to attend at the neutral evaluation?

ABSOLUTELY.

The neutral evaluation **can only** be effective if both parties, as well as their representatives are present to hear the information and the opinion of the neutral evaluator.

What happens at neutral evaluation?

Before the neutral evaluation occurs, the neutral evaluator will read the summaries of the parties and the documentation filed.

The neutral evaluation will be scheduled for one half day and can take place either at the offices of the Commission in North York, or by telephone conference.

The format of the neutral evaluation is flexible and can be adapted to meet the particular needs of the parties and the circumstances of the case. At the beginning of the evaluation the neutral evaluator will generally review various alternative approaches to the neutral evaluation and ask the parties which format would be most conducive to resolving their dispute.

Usually the neutral evaluator will hear brief oral submissions from each party, highlighting the positions and supporting evidence of each side. The neutral evaluator may then have questions of each party regarding the evidence, the conclusions to be taken from the evidence, or the parties' interpretation of the pertinent legislation.

After considering all of the evidence and arguments, both written and oral, the neutral evaluator will generally attempt to facilitate settlement between the parties, prior to providing an oral opinion of the probable outcome of a hearing. The neutral evaluator may meet with each side on consent, or may break to allow parties a private opportunity to discuss settlement options generated during the process. When the dispute settles, the neutral evaluator will prepare a report identifying the issues that were evaluated and settled.

WHAT HAPPENS IF THE CASE DOESN'T SETTLE AT NEUTRAL EVALUATION?

If the neutral evaluation does not resolve all of the issues in dispute, the neutral evaluator will set a date for the arbitration hearing. A pre-hearing discussion will **not** be scheduled. Therefore, neither party will be able to obtain any production orders prior to the arbitration hearing, except in extraordinary circumstances where new information, which could not have been anticipated, has come to light since the neutral evaluation.

The neutral evaluator will prepare a written report confirming issues which remain in dispute. The opinion of the neutral evaluator is confidential and will **not** be included in the written report. The parties **cannot** communicate the neutral evaluator's opinion to the hearing arbitrator. The hearing arbitrator will **not** be the same person as the neutral evaluator.

For information about arranging a Private Neutral Evaluation, see **Practice Note 5**, "Mediator Referral to Private Neutral Evaluation".

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1- 800 517-2332

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THIS PRACTICE NOTE IS INTENDED FOR USE BY APPLICANTS AND INSURERS

THE ARBITRATION PRE-HEARING DISCUSSION

Parties to an arbitration are usually required to participate in one or more pre-hearing discussions of their case before the actual arbitration hearing. This discussion generally takes place within 6 to 8 weeks after the applicant receives the insurance company's ***Response by Insurer***.

Parties are expected to have exchanged all documents identified in the ***Application for Arbitration*** and the ***Response by Insurer***, or to have provided the other party with a written explanation why a document has not been provided, prior to the pre-hearing discussion.

WHY DO WE HAVE A PRE-HEARING DISCUSSION?

The pre-hearing discussion gives the parties an opportunity to talk with an arbitrator about the case before the hearing. The arbitrator will:

- attempt to settle some or all of the issues in dispute;
- clarify the issues to be arbitrated;
- explain the rules of the hearing;
- review what witnesses and evidence will be brought to the hearing;
- review each party's list of outstanding document requests and disputed items;
- decide which documents should be exchanged where the parties cannot agree;
- set a mutually convenient date and location for the hearing.

DOES EVERYONE MEET IN PERSON?

The pre-hearing discussion can be held in person or by telephone conference call, at the arbitrator's discretion.

Whether the discussion is in person or by telephone, both the applicant and the representative from the insurance company should take part. Arbitrators have noted that the absence of parties from the pre-hearing frequently impedes settlement discussions – even when the parties are represented by legal counsel who participate in the pre-hearing on their behalf.

Clients who cannot participate in person are expected to be available to participate in the pre-hearing discussion by phone.

An arbitrator will chair the discussion. The arbitrator who chairs the pre-hearing discussion will generally not be the one who hears the case.

WHAT DO I BRING TO THE PRE-HEARING DISCUSSION?

Don't wait for the pre-hearing discussion to begin preparing your case.

Get updated medical information, financial documents, or recent tax returns **BEFORE** the pre-hearing discussion.

Parties must exchange copies of all the documents they intend to use at the actual hearing well before the pre-hearing discussion. (See **Practice Note 4**, "Exchange of Documents").

If you have been unable to exchange documents in advance, please bring along two sets of photocopies: one for the arbitrator and one for the other party. These photocopies will be exchanged at the pre-hearing.

The arbitrator will ask about the witnesses who will be called during the hearing. Witnesses typically provide information about the accident, about the applicant's employment and income, or about the applicant's medical condition.

How long after the pre-hearing discussion until the hearing?

At the pre-hearing, the arbitrator will set a convenient date for the hearing. Generally, this date will be within four to six months of the pre-hearing discussion. Once this date is set, changes will only be made in special circumstances. (See **Practice Note 9**, "Adjournments").

You must have all your papers, updated medical reports and witnesses ready for the hearing date set.

How do I get more information?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

ATTENDANCE OF A WITNESS TO AN ARBITRATION HEARING BY SUMMONS

If you need a witness to attend an arbitration hearing you must arrange four things: advanced notification to the potential witness, the summons, an affidavit attesting to the summons, and the correct attendance fees.

First, you must notify a potential witness of your intention to call him or her to give evidence at the hearing at least **30 days** before the first day of your arbitration hearing.

Next, the witness must receive a summons (called a ***Summons to Witness***) to the hearing and payment for attending at least 5 business days before the first day of the hearing.

Finally, the person who delivers the summons must file an affidavit (swearing that the summons and witness fees were delivered in person) with the Commission.

SUMMONING A WITNESS

Step 1: Notice of intention to call witness to attend the arbitration

The Dispute Resolution Practice Code requires each party to identify the expert and lay witnesses they intend to call to the hearing, as part of the pre-hearing process. In addition, **Rule 41** of the **Code** requires every party to notify a potential witness of the intention to call him or her to give evidence at the hearing at least **30 days** before the first day of the hearing. A failure to provide proper notice to a potential witness may result in the arbitrator excusing the witness from attending at the hearing.

Step 2: Getting the proper forms

If you wish to summon a witness, get a ***Summons to Witness*** form (**FORM N** found in **Section G** of the **Code**) from the Commission. The Commission can mail or fax the form to you, or it can be picked up in person. If you wish to have a witness at your hearing, you should start this process as early as possible before the hearing date.

Step 3: Filling out the form

Be sure you include all necessary information on the ***Summons to Witness*** form before you pass it to your witness:

√ the Commission's file number;

√ your name;

√ the name of the insurance company;

√ the name and address of the person receiving the summons (witness);

√ the date, time and place of the hearing;

√ a list of the documents the witness should bring to the hearing.

Step 4: Delivering the Form

The summons must be delivered to the witness in person not less than 5 business days before the first day of hearing. (**Rule 73** of the Dispute Resolution Practice Code). You or your representative can deliver the summons, or you can hire a process server (check the Yellow Pages of your telephone directory). You must also be sure to pay the witness at this time. Remember, you must deliver the ***Summons to Witness*** at least 5 business days before the commencement of the hearing.

CALCULATING PAYMENT TO THE WITNESS

The standard witness fee is $50 a day for each day of the hearing the witness attends. But an expert witness, like a doctor or an accountant, often charges more. You should speak directly to your doctor or other expert witness to determine any additional fees they may charge in connection with their attendance at the hearing. You are also responsible for paying travel expenses to the witness. These vary:

- If a witness lives in the city where the hearing is held, you are responsible for $3 per day in traveling expenses;
- If a witness lives outside of the city but within 300 kilometres, you must pay 24 cents a kilometre each way;
- If the witness lives more than 300 kilometres from the hearing, you must pay travel expenses equalling the minimum return air fare, plus 24 cents a kilometre, each way, from the witness's home to the airport and from the airport to the hearing;
- Overnight accommodation and meals can be up to $75 per day.

Remember, the witness must receive this payment when he or she receives the summons.

IMPORTANT

Be sure you keep your copies of the summons and of the money order or cheque that goes to the witness for fees and expenses. At the end of your hearing, you can ask the arbitrator to award you your costs for witness fees, travel expenses and swearing the ***Affidavit of Service for a Summons to Witness***. (For more information, see **Schedule to Expense Regulation** found in **Section F** of the **Code**).

GETTING AN AFFIDAVIT OF SERVICE

Before the hearing, the Commission must receive a signed affidavit (called an ***Affidavit of Service for a Summons to Witness***, **FORM O**, found in **Section G** of the **Code**) swearing that the witness was handed the summons in person and paid to attend the hearing. The affidavit can be delivered to the Commission in person or by regular, registered or certified mail. It can also be faxed to the Commission as long as the original is mailed to the Commission.

In the ***Affidavit of Service for a Summons to Witness***, the person who delivered your summons swears an oath that he or she has personally handed the summons and required witness fee to the witness. Swearing, or affirming, is done in front of a commissioner of oaths such as a lawyer, notary public, or a designated law clerk or paralegal. Forms will be available wherever you find a designated commissioner of oaths. You may have to pay the commissioner of oaths for this service.

WHAT HAPPENS IF A WITNESS DOESN'T SHOW UP FOR THE HEARING?

Having your witness attend the hearing may be critical to your case. It is vital that your witness is properly summoned and that you keep copies of all documents. If your witness does not attend the hearing, fails to stay, or does not bring the documents listed on the summons, you may not be able to prove your case.

What happens next depends largely on whether the summons, the affidavit and witness fees were properly prepared and delivered a minimum of 5 business days before the first day of the hearing. The arbitrator will review the affidavit to ensure that everything that needed to be done was properly done. If your copies of the documents show that the witness was summoned properly, the arbitrator may grant an adjournment and set another hearing date, or a sheriff's warrant may be obtained through the courts, to have the witness brought to the hearing.

HOW DO I GET MORE INFORMATION?

Our telephone numbers are:

- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1-800-517-2332

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Financial Services Commission of Ontario
Commission des services financiers de l'Ontario

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Dispute Resolution Group / Groupe de règlement des différends

THIS PRACTICE NOTE IS INTENDED FOR USE BY APPLICANTS AND INSURERS

ADJOURNMENTS

The Commission has an obligation to conduct arbitrations efficiently and speedily. Parties are contacted and agree to pre-hearing and hearing dates well in advance of the dates set. Therefore, adjournments are granted only sparingly once dates have been set.

WHEN WILL ADJOURNMENTS BE GRANTED?

Requests for adjournments will only be considered in three circumstances:

- in cases of personal emergencies, such as serious illnesses or deaths in the family
- for valid reasons relating to the hearing itself, such as an imminent settlement, or medical or other critical evidence that is **UNAVOIDABLY** delayed
- when a lawyer is involved in a trial or other proceeding that was scheduled to conclude before the start of the Commission proceeding and which has continued or been held over into the time scheduled for the Commission proceeding.

WHEN WILL ADJOURNMENTS BE REFUSED?

Adjournments will normally be refused if they do not fall into one of the three categories mentioned above. Common circumstances in which adjournments are refused include the following:

- scheduling conflicts for the parties or their lawyers (except for conflicts with pre-set trial dates as noted above)
- where the parties have not made reasonable efforts to comply or delayed their compliance with undertakings and orders made at the pre-hearing
- where the parties have not made early arrangements to ensure availability of documents or the attendance of witnesses
- where parties have not made early arrangements for further medical examinations, assessments or follow-up.

NOTICE REQUIREMENTS

Seven days notice is generally required for an adjournment request. A request for an adjournment of a pre-hearing discussion or arbitration proceeding must be made in writing to the Office of the Registrar with a copy to the other parties. A request for an adjournment of an appeal or variation/revocation must be made to the Director of Arbitrations. Such requests must outline the reasons for the adjournment and indicate whether all other parties consent to it. Alternative hearing dates that are acceptable to all parties must be proposed. The party requesting an adjournment should contact the other parties involved in the hearing to arrange acceptable alternative dates before asking for the adjournment.

The Office of the Registrar, the Director, or an adjudicator may deal with requests on less than seven days notice by conference call.

THE NEW HEARING DATE

It is advisable to provide more than one alternative hearing date for the proposed adjournment. An adjournment "sine die" (that is, with no new hearing date set) will rarely be granted except in extraordinary circumstances.

WRITTEN CONFIRMATION OF ADJOURMENT FROM THE COMMISSION

Every request for an adjournment receives a written response from the Commission. No adjournment is granted without written confirmation to the parties and their representatives. If you have not received written confirmation of your adjournment request prior to the scheduled date of the proceeding, you are required to attend at the proceeding on the originally scheduled date to speak to an arbitrator on the issue of the adjournment request.

HOW DO I GET MORE INFORMATION?

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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

PROCESS FOR SETTLING DISPUTES BETWEEN AUTO INSURANCE COMPANIES

This Note is to advise claimants and insurers of the provisions of Regulation 283/95 **Disputes Between Insurers** ("the Regulation"). The Regulation ensures that claimants will have access to statutory accident benefits where two or more insurers are disputing which one has the responsibility to pay accident benefits. The Regulation also requires that disputes between insurers about which insurer is required to pay accident benefits be referred to private arbitration under the *Arbitration Act*, 1991. Such disputes between insurers are no longer dealt with through the dispute resolution process at the Commission. A copy of this Regulation is included with this Practice Note.

BACKGROUND - SECTION 268 OF THE *INSURANCE ACT*

Section 268 of the *Insurance Act* creates rules for determining which automobile insurance company is responsible for paying accident benefits in a given set of circumstances. The section is used to determine which insurer is liable to pay benefits when the claimant does not have an auto insurance policy of his or her own, or where coverage may be available under more than one policy. In some circumstances, s.268 requires a specific insurance company to deal with the claim. In other situations, two or more companies may be liable to pay benefits, and a claimant may choose the insurer from which to claim benefits. An excerpt from s.268 outlining the priority rules for paying benefits is attached.

Disputes between insurers can arise in various ways. For example, in cases where a passenger involved in a car accident has no auto insurance of his or her own, it may not be clear whether the passenger looks to the insurance policy of their spouse, parents, or another vehicle involved in the accident. A spouse or dependant of a named insured must look to that policy for payment of accident benefits. A person who is not a spouse or dependant will have to look to the insurance policy of a vehicle involved in the accident.

REGULATION 283/95 - DISPUTES BETWEEN INSURERS

This Regulation ensures that accident victims will not be denied statutory accident benefits simply because the first insurer applied to for benefits thinks another insurer should pay. Section 2 of the Regulation requires the **first** insurer that receives an application to adjust the claim and to pay benefits to which the insured person is entitled, pending resolution of any dispute as to which insurer is required to pay benefits (see s.2 of the Regulation). The first insurer cannot refuse to pay accident benefits on the basis that the insured person may have approached the wrong insurance company.

If an insurer believes that another insurance company ought to be paying the claim, it is obliged to notify the other company **within 90 days** of receiving a completed application for statutory accident benefits. It also must notify the insured person that it believes another company is responsible, and that it proposes to transfer the claim to that company. If the insured person objects to the claim being transferred, he or she must notify the insurer of the objection **within 14 days**. Otherwise, the insured person will not be

able to participate as a party in the dispute between insurers as to which insurer should pay.

The Regulation removes these disputes between insurers from the dispute resolution process at the Commission. Disputes between insurers are now settled through private arbitration under the *Arbitration Act, 1991*. If the insured person has given notice that he or she objects to the transfer of the claim, the insured person, or his or her representative, may take part in the arbitration of the dispute under the *Arbitration Act*. All such arbitrations must be commenced **within a year** from the date that the first insurance company gave notice that it believes another company is liable.

Obligation of insurers

The Regulation requires the insurer who first receives an application for benefits to consider entitlement and adjust the claim as it would any other, including seeking an independent medical examination, or initiating the designated assessment or mediation process as appropriate. It does not allow the insurer to ignore a claim where it believes another insurer is liable to pay under s.268 of the *Insurance Act*.

Where the first insurer believes it is the wrong insurer and also claims that the insured person is not entitled to benefits under the *Statutory Accident Benefits Schedule*, it must respond to the claim on two separate fronts – issuing the notice to the insurer it believes is responsible under s.268, and following the procedures for denying a claim through the normal dispute resolution process at the Commission.

Obligations of claimants

The Regulation is intended to ensure that a claimant is not caught between two insurers, each of which disputes its liability to pay benefits. However, the Regulation cannot operate properly without a clear record as to which insurer first receives an application for benefits. As a result, claimants are advised to carefully consider which insurer is obligated to pay the claim under the provisions of s.268 of the *Insurance Act*, **before** submitting an application. In order to prevent disputes over which insurer first received an application, **the claimant is advised to initially submit only one application for benefits.**

If the insurer to whom the application was submitted does not respond to the claim, or delays or denies coverage on the basis that another insurer is liable to pay, under s.268 of the *Insurance Act*, the claimant should contact the Office of the Insurance Ombudsman of the Commission. The claimant may also file an ***Application for Mediation*** against the first insurer regarding a delay in payment or failure to respond.

Under the Regulation a claimant is required to provide the insurers with all the relevant information that is needed to determine which insurer is required to pay (see s.6 of the Regulation). He or she is not required to participate in the private arbitration that will occur if the dispute is not settled. A claimant is entitled to object to the transfer of a claim (unless the claim has been made against the Motor Vehicle Accident Claims Fund – s.11) and to participate as a party in the private arbitration if he or she files an objection **within 14 days** of receiving notice of the dispute (see s.5 of the Regulation).

Liability under section 268 of the *Insurance Act* versus entitlement under the *Statutory Accident Benefits Schedule*

In some cases insurers have expressed uncertainty about how they should deal with a claim where there is a dispute between insurers.

If the insurer's position is that the claimant is not eligible for accident benefits, then the dispute should be addressed by commencing mediation at the Commission.

If the insurer's position is that responsibility to pay belongs to another insurer, then it is a dispute under Regulation 283/95. The first insurer must notify the other insurer and the claimant, as

outlined above, and resolve that dispute through private arbitration.

If the first insurer has a number of reasons for denying the claim, some of which are based on lack of entitlement, and others based on a liability question, it should dispute the claim in the normal manner before the Commission on the entitlement dispute. It should also issue a notice under the Regulation to the insurer that it believes would be required to pay, in the event it is unsuccessful on the entitlement issues. The second insurer may seek permission to join the proceeding concerning entitlement to accident benefits started by the first insurer at the Commission.

This is a brief summary of a complex topic. Please refer to Regulation 283/95 and the Insurance Act for more precise information.

How do I get more information?

The Commission telephone numbers are:

From Toronto, call: (416) 250-6714
From outside Toronto, phone: 1-800-517-2332

To reach the Office of the Insurance Ombudsman at the Commission, the telephone numbers are:

From Toronto, call (416) 250-7250
From outside Toronto, phone 1-800-668-0128

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EXCERPT FROM THE *INSURANCE ACT* R.S.O. 1990, C.1.8, AS AMENDED

STATUTORY ACCIDENT BENEFITS

268.—(1) Every contract evidenced by a motor vehicle liability policy, including every such contract in force when the *Statutory Accident Benefits Schedule* is made or amended, shall be deemed to provide for the statutory accident benefits set out in the *Schedule* and any amendments to the *Schedule*, subject to the terms, conditions, provisions, exclusions and limits set out in that *Schedule*.

LIABILITY TO PAY

(2) The following rules apply for determining who is liable to pay statutory accident benefits:

1. In respect of an occupant of an automobile,
   i. the occupant has recourse against the insurer of an automobile in respect of which the occupant is an insured,
   ii. if recovery is unavailable under subparagraph i, the occupant has recourse against the insurer of the automobile in which he or she was an occupant,
   iii. if recovery is unavailable under subparagraph i or ii, the occupant has recourse against the insurer of any other automobile involved in the incident from which the entitlement to statutory accident benefits arose,
   iv. if recovery is unavailable under subparagraph i, ii or iii, the occupant has recourse against the Motor Vehicle Accident Claims Fund.
2. In respect of non-occupants,
   i. the non-occupant has recourse against the insurer of an automobile in respect of which the non-occupant is an insured,
   ii. if recovery is unavailable under subparagraph i, the non-occupant has recourse against the insurer of the automobile that struck the non-occupant,
   iii. if recovery is unavailable under subparagraph i or ii, the non-occupant has recourse against the insurer of any automobile involved in the incident from which the entitlement to statutory accident benefits arose,
   iv. if recovery is unavailable under subparagraph i, ii or iii, the non-occupant has recourse against the Motor Vehicle Accident Claims Fund.

LIABILITY

(3) An insurer against whom a person has recourse for the payment of statutory accident benefits is liable to pay the benefits.

CHOICE OF INSURER

(4) If, under subparagraph i or iii of paragraph 1 or subparagraph i or iii of paragraph 2 of subsection (2), a person has recourse against more than one insurer for the payment of statutory accident benefits, the person, in his or her absolute discretion, may decide the insurer from which he or she will claim the benefits.

(5) Despite subsection (4), if a person is a named insured under a contract evidenced by a motor vehicle liability policy or the person is the spouse or same-sex partner or a dependant, as defined in the *Statutory Accident Benefits Schedule*, of a named insured, the person shall claim statutory accident benefits against the insurer under that policy.

SAME

(5.1) Subject to subsection (5.2), if there is more than one insurer against which a person may claim benefits under subsection (5), the person, in his or her discretion, may decide the insurer from which he or she will claim the benefits.

SAME

(5.2) If there is more than one insurer against which a person may claim benefits under subsection (5) and the person was, at the time of the incident, an occupant of an automobile in respect of which the person is the named insured or the spouse or same-sex partner or a dependant of the named insured, the person shall claim statutory accident benefits against the insurer of the automobile in which the person was an occupant.

ONTARIO REGULATION 283/95
DISPUTES BETWEEN INSURERS

1. All disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this Regulation.

2. The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the Act.

3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

(2) An insurer may give notice after the 90-day period if,

(a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the Act; and

(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

(3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall be resolved in an arbitration under section 7.

4. An insurer that gives notice under section 3 shall also give notice to the insured person using a form approved by the Commissioner.

5. (1) An insured person who receives a notice under section 4 shall also advise the insurer paying benefits in writing within 14 days whether he or she objects to the transfer of the claim to the insurers referred to in the notice.

(2) If the insured person does not advise the insurer within 14 days that he or she objects to the transfer of the claim, the insured person is not entitled to object to any subsequent agreement or decision to transfer the claim to the insurers referred to in the notice.

(3) An insured person who has given notice of an objection is entitled to participate as a party in any subsequent proceeding to settle the dispute and no agreement between insurers as to which insurer should pay the claim is binding unless the insured person consents to the agreement or 14 days have passed since the insured person was notified in writing of an agreement and the insured person has not initiated an arbitration under the *Arbitrations Act, 1991*.

6. The insured person shall provide the insurers with all relevant information needed to determine who is required to pay benefits under section 268 of the Act.

7. (1) If the insurers cannot agree as to who is required to pay benefits or if the insured person disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the *Arbitration Act, 1991*.

(2) The insurer paying benefits under section 2, any other insurer against whom the obligation to pay benefits is claimed or the insured person who has given notice of an objection to a change in insurers under section 5 may initiate the arbitration but no arbitration may be initiated after one year from the time the insurer paying benefits under section 2 first gives notice under section 3.

8. (1) Except as provided in this Regulation, the *Arbitration Act, 1991* applies to an arbitration under this Regulation.

(2) The decisions of an arbitrator made under this Regulation shall be public.

9. (1) Unless otherwise ordered by the arbitrator or agreed to by all the parties before the commencement of the arbitration, the costs of the arbitration for all parties, including the cost of the arbitrator, shall be paid by the unsuccessful parties to the arbitration.

(2) The costs referred to in subsection (1) shall be assessed in accordance with section 56 of the *Arbitration Act, 1991*.

10. (1) If an insurer who receives notice under section 3 disputes its obligation to pay benefits on the basis that other insurers, excluding the insurer giving notice, have equal or higher priority under section 268 of the Act, it shall give notice to the other insurers.

(2) This Regulation applies to the other insurers given notice in the same way that it applies to the original insurer given notice under section 3.

(3) The dispute among the insurers shall be resolved in one arbitration.

11. If the Motor Vehicle Accident Claims Fund receives an application for benefits, sections 4 and 5 do not apply and the insured person is not entitled to initiate or participate as a party in an arbitration under section 7.

Financial Services Commission of Ontario
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PRACTICE NOTE
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Dispute Resolution Group / Groupe de règlement des différends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

JURISDICTIONAL ISSUES ARISING IN MEDIATION

This Practice Note is to advise claimants and insurers of the policy of the Financial Services Commission of Ontario ("Commission") on jurisdictional issues which frequently arise upon entry to the mediation process.

A. GENERAL JURISDICTION:

Mediation at the Commission helps to resolve disputes concerning benefits available under the various *Statutory Accident Benefits Schedules ("SABS")* passed since June 22, 1990. These benefits are available in respect of personal injuries from motor vehicle accidents. Mediation does not deal with claims that arose out of accidents occurring before June 22, 1990. You may wish to contact the Office of the Insurance Ombudsman at the Commission for information relating to disputes against an insurer that are beyond the mandate of Mediation Services.

1. NO MEDIATION OF CLAIMS FOR PROPERTY DAMAGE

Mediation Services does not accept applications to mediate disputes concerning damage to automobiles or other property except as specifically set out in the *SABS*.

2. NO MEDIATION OF A CLAIM FOR WEEKLY BENEFITS FOR THE FIRST WEEK OF DISABILITY

The *SABS* provide that no weekly benefit is payable for the first week of disability. Mediation Services does not accept applications to mediate a claim for entitlement to a weekly benefit for the first week of disability.

3. NO MEDIATION WHERE A CLAIM FOR ACCIDENT BENEFITS HAS NOT BEEN SUBMITTED TO INSURER

Claimants may use the services of mediation when an accident benefit has been claimed from an automobile insurer and denied. Claimants are entitled to receive written notice from the insurer of a refusal to pay a claim along with an explanation for the refusal. Mediation Services does not accept an ***Application for Mediation*** where the claimant has not first submitted his or her claim to the insurer. Where a claim has been submitted to an insurer and the time specified in the regulation for reviewing the claim by the insurer has expired, Mediation Services will accept the ***Application for Mediation*** on the basis of the insurer's deemed denial.

4. PREVIOUSLY MEDIATED ISSUES

Mediation Services does not re-mediate issues that have been dealt with in a previous mediation as reflected in the **Report of Mediator**, whether the issues were noted as resolved or not resolved. The options after a failed mediation, or a mediation where issues were resolved but the settlement broke down subsequent to the mediation are:

- take no further steps;
- file an ***Application for Arbitration*** at the Commission;
- appoint a private arbitrator pursuant to the provisions of the *Arbitration Act* and the *Insurance Act*;
- request Neutral Evaluation, privately or through an ***Application for Arbitration*** at the Commission;
- commence a court action.

5. SPECIAL AWARD

Mediation Services does not accept an ***Application for Mediation*** of a claim for a Special Award, as this is not a benefit provided under the *SABS*. A special award is a matter of the exercise of an arbitrator's discretion.

6. LEGAL EXPENSES

Mediation Services does not accept applications to mediate a dispute over legal fees and disbursements, as this is not a benefit provided under the *SABS*.

An award of legal expenses is a hypothetical matter that does not arise until the arbitration or court proceeding is concluded. Therefore, the issue must be addressed as part of the arbitration or court proceeding.

B. EXPIRY OF LIMITATION PERIODS

1. TIME LIMIT TO APPLY TO INSURER FOR ACCIDENT BENEFITS

(i) The *Statutory Accident Benefits Schedules* establish time limits for applying for accident benefits. However, late applications must be accepted if the insured person has a "reasonable excuse" for the delay.

Disputes concerning whether a delay was reasonable will be accepted for mediation. The preliminary issue concerning the reasonableness of the delay will be mediated along with the disputes concerning the statutory accident benefits claimed in the ***Application for Mediation.***

(ii) **Exception.** There is an exception for accidents that occurred on or after June 22, 1990 and before January 1, 1994. The *Schedule* (Bill 68) provides that an injured person must apply to their insurer for accident benefits within two years after the accident. If no claim for accident benefits is made to the insurer within two years, the Commission has no jurisdiction to mediate. However, disputes concerning whether a claim for benefits was made to the insurer within two years will be accepted for mediation. The preliminary issue of whether the limitation period to claim benefits has expired, will be mediated along with the disputes concerning statutory accident benefits claimed in the ***Application for Mediation.***

2. TIME LIMIT TO APPLY TO THE COMMISSION FOR MEDIATION OF DISPUTES OVER BENEFITS

The *SABS* provide that a claimant may commence mediation at the Commission within two years of the insurer's written refusal to pay the benefit claimed. Mediation Services does not accept an ***Application for Mediation*** if it is made to the Commission beyond two years. However, disputes concerning whether an ***Application for Mediation*** was made to the Commission within two years of the insurer's written refusal to pay benefits will be accepted for mediation. The preliminary issue of the expiry of the limitation period will be mediated, along with the disputes concerning statutory accident benefits claimed in the ***Application for Mediation.***

If the limitation period issue arises in the Mediation intake process, the mediation caseworker will notify the claimant of the limitation period and will require the claimant to provide a letter confirming that he or she wishes to dispute the expiration of the time limit. If the issue is raised by the insurer during the mediation process, no letter from the claimant is required.

C. DISPUTES BETWEEN INSURERS – LIABILITY REGULATION 283/95

Mediation Services does not deal with disputes about which of several insurers is required to pay the claimant's *SABS* (See **Practice Note 10,** "Process for Settling Disputes Between Auto Insurance Companies (Reg. 283/95)").

Mediation Services will accept an ***Application for Mediation*** made against the **first insurer** to receive a completed application for accident benefits, concerning the claimant's entitlement to benefits. A mediation caseworker will clarify with the parties which insurer (licensed in Ontario or subject

to Ontario law through an undertaking), first received the completed application for accident benefits.

Disputes concerning which insurer was the first to receive the completed application for *SABS* will be mediated as a preliminary issue, along with the disputes concerning accident benefits claimed in the ***Application for Mediation***.

D. FULL AND FINAL RELEASE – SETTLEMENT REGULATION 664 AS AMENDED BY O.R. 780/93

Mediation Services does not accept an ***Application for Mediation*** where a claimant has signed a valid full and final release of his or her entitlement to *SABS* arising from the motor vehicle accident in question and the insurer has complied with the requirements of the **Settlement Regulation.**

Mediation Services will accept an ***Application for Mediation*** where:

(i) the claimant disputes the validity of the settlement, such as whether the insurer has complied with the requirements of the **Settlement Regulation.**

(ii) a court or private arbitrator has set aside a previous settlement on such grounds as fraud, duress or misrepresentation;

(iii) the parties agree to set aside the settlement;

(iv) the claimant resiles from a settlement within the 48 hour cooling off period in accordance with the **Settlement Regulation** (See **Practice Note 2,** "Reaching a Settlement within the Dispute Resolution Process");

The preliminary issue of the validity of the settlement will be mediated along with the disputes concerning statutory benefits claimed in the ***Application for Mediation.***

Mediation Services will not re-mediate issues that have been dealt with in a previous Commission mediation as reflected in the **Report of Mediator.** The options after a mediation where issues were reported as resolved but the validity of the settlement is now in dispute, are:

- take no further steps
- file an ***Application for Arbitration*** at the Commission
- appoint a private arbitrator pursuant to the provisions of the *Arbitration Act* and the *Insurance Act.*
- request Neutral Evaluation, privately or through the Commission
- commence a court action.

E. NON-ATTENDANCE AT A DESIGNATED ASSESSMENT CENTRE (DAC)

DACs have been in place across Ontario since January 1994. Insured persons and insurers can use DACs when they need an expert, neutral third-party opinion about the injuries received in car accidents and the care or treatment needed by an injured party.

The five types of DAC assessments are:

- Disability
- Medical and Rehabilitation
- Attendant Care
- Catastrophic Impairment [Bill 59 only]
- Residual Earning Capacity [Bill 164 only]

(For additional information on DACs, see **Practice Note 12,** "What Claimants need to know about Designated Assessment Centres")

1. NON-ATTENDANCE AT A DISABILITY DAC

Where a claimant requests a DAC for the purpose of assessing entitlement to weekly benefits but does not attend, the claimant can still apply for mediation at the Commission. If the insurer wants to raise the preliminary question of whether the claimant made him or her/self reasonably available for the assessment, that issue will be mediated along with the other disputes.

2. NON-ATTENDANCE AT A MEDICAL, REHABILITATION OR ATTENDANT CARE DAC

(i) For accidents occurring on or after November 1, 1996 (Bill 59), a claimant's failure to attend a DAC assessment scheduled for the purpose of assessing the claimant's entitlement to medical benefits, rehabilitation benefits or attendant care benefits does NOT prevent the claimant from proceeding to mediation as long as the claimant has made him or her/self reasonably available for the assessment.

Disputes concerning whether the claimant has made him or her/self reasonably available for the DAC assessment, will be accepted for mediation. This preliminary issue will be mediated along with the disputes concerning statutory accident benefits claimed in the ***Application for Mediation.***

(ii) For accidents occurring on or after January 1, 1994 and before November 1, 1996 (Bill 164), Mediation Services will NOT accept an ***Application for Mediation*** with respect to medical benefits, rehabilitation benefits or attendant care benefits if the claimant has failed to attend a DAC assessment requested by the insurer prior to filing the ***Application for Mediation.***

3. NON-ATTENDANCE AT A RESIDUAL EARNING CAPACITY DAC ("REC DAC")

For accidents occurring on or after January 1, 1994 and before November 1, 1996 (Bill 164), a claimant may be eligible for a Loss of Earning Capacity Benefit ("LEC Benefit"). The issue of a claimant's entitlement to a LEC Benefit will be accepted for mediation.

However, where a claimant disputes the insurer's determination of his or her residual earning capacity, Mediation Services will NOT assign the dispute to a Mediator until the claimant has been assessed by a REC DAC. The ***Application for Mediation*** will be accepted and opened, and will be held in abeyance pending the completion of the REC DAC assessment and report. At the request of the claimant, the mediation will proceed with respect to the non-LEC Benefit issues claimed in the ***Application for Mediation***, or on the issue of entitlement to the LEC Benefit only.

F. NON-ATTENDANCE AT AN INSURER'S MEDICAL EXAMINATION

A claimant's failure to attend a medical examination arranged by the insurer, does not prevent the claimant from proceeding to mediation, provided the claimant has made him or her/self reasonably available for such an examination.

The preliminary issue of whether the claimant has made him or her/self reasonably available for an insurer's medical examination will be accepted for mediation along with the disputes concerning the accident benefits claimed in the ***Application for Mediation.***

G. APPLICATION FOR A NON-EARNER BENEFIT SUBMITTED TO THE INSURER PRIOR TO 26 WEEKS

For accidents occurring on or after November 1, 1996 (Bill 59), a claimant may be eligible to receive a Non-Earner Benefit, 26 weeks after the onset of disability. Mediation Services does not accept applications to mediate the issue of entitlement to a Non-Earner Benefit prior to the expiry of the 26 week period.

HOW DO I GET MORE INFORMATION?

The Commission telephone numbers are:

From Toronto, call: (416) 250-6714
From outside Toronto, phone: 1-800-517-2332

To reach the Office of the Insurance Ombudsman at the Commission, the telephone numbers are:

From Toronto, call (416) 250-7250
From outside Toronto, phone 1-800-668-0128

Cette publication est Ègalement disponible en français

Financial Services Commission of Ontario
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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

WHAT CLAIMANTS NEED TO KNOW ABOUT DESIGNATED ASSESSMENT CENTRES

WHAT IS A DAC?

If you are claiming accident benefits as a result of a motor vehicle accident that occurred on or **after** January 1, 1994, and you have a disagreement with your insurer over your entitlement to, or the amount of, a particular benefit, you may need to attend a Designated Assessment Centre, or DAC, to help in the resolving of the dispute.

DACs have been set up throughout Ontario since 1994 to give unbiased opinions about the injuries of car accident victims and the care or treatment they need.

DACs are independent clinics with many different kinds of medical and rehabilitation professionals on staff. Your assessment will be completed by the type of professional you need.

DACs are not run by insurance companies nor by the government. You do not have to pay any fees to have a DAC assessment.

Each DAC must be approved by the Minister's Committee on the DAC System (DAC Committee). Members of the DAC Committee are appointed by the Minister of Finance and include health care professionals, insurance company representatives, consumer representatives and lawyers. The DAC Committee issues **DAC Assessment Guides** to assist DACs in writing reports that are fair and based on the most up-to-date medical information.

There are five types of DAC assessments:
- Disability
- Medical and Rehabilitation
- Attendant Care
- Catastrophic Impairment [Bill 59 only]
- Residual Earning Capacity [Bill 164 only]

The health care professionals at each DAC only conduct the type of assessments that the DAC has been authorized to do. Some DACs have been approved to do more than one type of assessment. If your case has more than one issue in dispute, you may need to have more than one assessment.

When you are referred to a DAC for an assessment, the insurer is required to select the DAC closest to your residence that is qualified to conduct the type of assessment you require.

WHY WOULD I GO TO A DESIGNATED ASSESSMENT CENTRE?

There are a number of reasons why you may choose to attend a DAC assessment. The type of assessment completed at a DAC depends on the nature of the dispute between you and your insurer. The following are some examples:

i) if you have claimed weekly benefits and your insurer thinks the injuries you suffered from your car accident have improved enough that you are no longer entitled to receive the benefit, your insurer will send you a form (OCF 17) stating that the insurer is going to stop paying your weekly benefits. In this case, if you do not agree that your benefits should stop, you may ask your insurer in *writing* to arrange for you to have a disability assessment.

ii) the insurer may ask you to attend a DAC to determine what level of attendant care is required by you or whether you qualify for benefits because of a catastrophic impairment. (Attendant Care and Catastrophic Impairment Assessments, or CAT).

iii) if you and your insurer cannot agree on whether medical or rehabilitation benefits proposed by your health care provider are reasonable and necessary to your recovery, the insurer may ask you to attend a DAC to obtain an opinion on the proposed treatment.

vi) if you have received a Loss of Earning Capacity offer from your insurer and you dispute the amount of that offer, you may request a Residual Earning Capacity DAC to help determine your ability to earn an income after 104 weeks from your accident. (This DAC only applies to you if your accident occurred on or after January 1, 1994 and before November 1, 1996.)

WHO CHOOSES WHICH DAC WILL DO MY ASSESSMENT?

Ontario insurance law sets out which DAC will conduct your assessment. You go to the DAC closest to your home that is approved to do the type of assessments you require. A list of DACs in the province and the types of assessments that they perform can be found on the Commission's website at **www.fsco.gov.on.ca**

For all assessment types, with the exception of Attendant Care and CAT DACs, if there is no DAC within 100 kilometres of your home, you and your insurer may agree to have another health care professional conduct your assessment.

If you and your insurer cannot agree on another health care professional, you **MUST** go to the DAC that is closest to your home no matter how far away it is.

If you think that you are being sent to the wrong DAC, talk to your insurer by contacting your insurance company's ombudsman liaison officer.

HOW IS AN ASSESSMENT DONE?

1. If a DAC assessment is required in your case, your insurer must arrange for a DAC assessment within 15 days from your written request for one.

If the DAC cannot start your assessment within 14 days after they have received a complete referral package from your insurer, you or your insurer can ask the next closest DAC to conduct your assessment.

2. Your personal health information is essential to ensuring that the DAC is as comprehensive as possible. As your health information is confidential, you must provide the DAC with a form (OCF 14) giving permission to your health care providers to give your reports and information to the DAC before the assessment starts.

The DAC cannot begin its assessment without the OCF 14 and failure to provide this document could delay the DAC assessment and possibly delay the payment of your benefits.

3. The insurer will refer you to a DAC using an OCF-11A form. The form specifies the benefit to be assessed by the DAC and lists all the information and reports the insurer has sent to the DAC to ensure a comprehensive assessment.

When you get your copy of the referral form (OCF-11A), you have an opportunity to provide the DAC with any additional information that you think is relevant to the assessment which the insurer has not listed in the original referral material. This must be sent to the DAC before your assessment begins.

4. The DAC will prepare an assessment plan that outlines the health care professionals who will conduct the assessment (including summaries of their practice summaries) and outlines what will be done in your assessment to address the issues referred to the DAC. This is done following a review of all the information the DAC has received from you and your insurer.

5. The assessment might involve more than one appointment and the DAC cannot issue its report until all of the components of the assessment plan

have been completed. Every effort should be made to attend the full assessment as insurance regulations state that if a person fails to make themselves reasonably available for an assessment, or fails to cooperate with the assessment, then the insurer may stop paying the benefit related to the assessment.

Please note that there may be cases where you will not be able to enter mediation at the Commission if you do not attend or finish a DAC assessment. As mediation is a mandatory first step to proceeding to arbitration or court, your dispute may be delayed. Please contact your insurer or your legal representative for further information on these restrictions.

If you cannot go to an appointment, you must tell the DAC and your insurer as soon as you know. The faster the assessment is done, the sooner you and your insurer can resolve the disagreement over your benefits.

6. Once the assessment is completed, the DAC will issue a report with the results of the assessment to you and your insurer.

The DAC's only job is to look into your case and write a report for you, your health care provider and the insurer, stating their opinion, on the questions before them including such issues as: whether or not you are still disabled within the meaning of the *Statutory Accident Benefits Schedule*; if you are entitled to a particular benefit; their opinion as to the amount of a benefit; and other matters according to the type of DAC assessment and the governing *Statutory Accident Benefits Schedule*.

7. An insurer may be required to pay your benefits based upon the opinion of the DAC assessors. If the DAC's disability assessment report says that you are still disabled because of the car accident, your insurer must continue to pay you weekly benefits. If a DAC says that a particular benefit is reasonable and necessary for your care and recovery, the insurer must pay the benefit.

WHAT IF I DO NOT AGREE WITH THE DAC REPORT?

If you do not agree with the DAC's opinion of your case, you should ask your insurer how it intends to deal with your claim as a result of the DAC's report.

If the DAC report does not help you or your insurer to resolve your claim for benefits, either of you can apply for mediation at the Commission to help you resolve your dispute. ***You must apply to the Commission within two years of the date of the insurer's written notice to deny your benefits.***

You can get an ***Application for Mediation*** from your insurer. If they do not have any available, you may contact:

Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, Box 85
Toronto, Ontario
M2N 6L9

or by calling (416) 250-7250 or 1-800-668-0128. The application form asks for your name, address, telephone number, the name and address of your insurer and details about your case

WHAT IF THE DAC DID NOT FOLLOW THE PROPER PROCEDURES OR I HAVE A COMPLAINT ABOUT A DAC?

The DAC Committee has established a process to deal with complaints regarding DACs which fail to conduct assessments in accordance with the Operational Procedures, General Guidelines and Assessment Protocols.

The objective of the complaint management process is to resolve systemic problems that may have led to the complaint rather than sanction specific DACs.

Specifically, the Accident Benefits Analysis Unit (ABAU), under the guidance of the DAC Committee's Operations Subcommittee, will review complaints related to:

- Compliance with principles of neutrality and unbiased behaviour throughout the entire DAC assessment process, including the DAC Report;
- Compliance with conflict of interest rules;
- Compliance with the General Guidelines, Operating Procedures and Assessment Protocols; and
- Compliance with capacity and service requirements.

The Operations Subcommittee and the ABAU cannot review complaints that fall outside its jurisdiction, including complaints relating to the business practices of an insurer, the professional conduct of a health care provider or complaints concerning the outcome of a DAC Report.

If you think one of the DAC Assessors acted unprofessionally or caused you harm, you can send a letter to the professional college that covers his or her professional group. Ask the DAC or your own family physician for the name and address of the college where your complaint should be sent.

Your letter to the college should give your name, address and telephone number, the name and business address of the person you are complaining about, and all the details about what happened. The college will contact you and look into your complaint.

However, If you think that the DAC failed to conduct assessments according to the General or Assessment Guides you can send a letter outlining your complaint to:

Accident Benefits Analysis Unit
Financial Services Commission of Ontario
5160 Yonge Street, Box 85
Toronto, Ontario
M2N 6L9

Your letter should give your name, address and telephone number, the name and address of the DAC, and all the details about your complaint. The Accident Benefits Analysis Unit will contact you and look into your complaint.

HOW CAN I GET MORE INFORMATION?

If you need general information about insurance, you can call and listen to the Commission's 24-hour toll-free taped information at 1-800-668-0128, or from Toronto at (416) 250-6750. If your question relates to DACs, call (416) 590-7137.

If you want copies of additional DAC material, please visit the Commission's website at **www.fsco.gov.on.ca** for further information.

If you feel you need legal advice, you may want to talk to a lawyer. The Law Society of Upper Canada will give you names of lawyers near you. Call the Law Society from Toronto at (416) 947-3330; from outside Toronto call 1-800-268-8326.

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Dispute Resolution Group / Groupe de règlement des différends

THIS PRACTICE NOTE IS INTENDED FOR USE BY INSURERS

WHAT INSURERS NEED TO KNOW WHEN REFERRING ISSUES TO A DESIGNATED ASSESSMENT CENTRE

WHAT IS THE DESIGNATED ASSESSMENT CENTRE SYSTEM (DAC SYSTEM)?

DACs have been set up throughout Ontario since 1994 to give unbiased opinions about the injuries of automobile accident victims and the care or treatment they need.

There are four founding principles to the DAC process: neutrality, cost-effectiveness, timeliness and comprehensiveness. The Minister's Committee on the Designated Assessment Centre System (DAC Committee) ensures that DACs continue to operate in a manner that upholds these principles.

Each DAC must be approved by the DAC Committee. Members of the DAC Committee are chosen by the Minister of Finance and include health care professionals, insurance company representatives, consumer representatives and lawyers. The DAC Committee also issues DAC Assessment Guidelines to assist DACs in writing reports that are fair and based on the most up-to-date information.

There are five types of DAC assessments:

- Disability
- Medical and Rehabilitation
- Attendant Care
- Catastrophic Impairment [Bill 59 only]
- Residual Earning Capacity [Bill 164 only]

The health care professionals at each DAC only do the type of assessments that the DAC has been approved to do. Some DACs have been approved to do more than one type of assessment. If the claim you are handling has more than one issue, you may need to arrange more than one assessment. Sometimes the separate assessments can be done by the DAC at the same time.

WHAT DETERMINES WHICH DAC SHOULD DO THE ASSESSMENT?

Ontario insurance law states which DAC will do the assessment. Insurers must refer the claimant to the DAC that is approved to do the type of assessments required that is ***closest to the claimant's home***.

For all types of assessment, with the exception of Attendant Care and Catastrophic Impairment DACs, if there is no appropriate DAC within 100 kilometres of the claimant's home, you and the claimant can agree to choose another health care professional to conduct the assessment. If you and the claimant cannot agree on the health care professional to conduct the assessment, the claimant MUST go to the DAC that is closest to the claimant's home no matter how far away it is.

The referral process is the responsibility of the insurer. The insurer must ensure that the claimant is sent to the appropriate DAC.

WHAT SHOULD BE INCLUDED IN THE REFERRAL PACKAGE?

The **Designated Assessment Referral** form **(OCF-11A)** is to be completed by the insurer. The Referral Question(s) asked by the insurer of the DAC should be clear, concise and reflect the relevant entitlement definitions found in the *SABS*.

Please note that a signed OCF 14 for each assessment is required by the DAC before it can begin the intake and assessment function. No referrals should be made by the insurer in the absence of a valid and signed OCF 14.

The List of Documents Forming the Referral Package should contain all the information the insurer has forwarded to the DAC and that will form part of the assessment. The insurer is required to send a copy of the **OCF-11A** to the DAC and another copy to the claimant.

This will ensure there is full disclosure of both the referral questions and the material sent to the DAC. It is the claimant's responsibility to provide the DAC with any other documents, such as recent test results, that may be useful in completing the assessment.

With more complete information, the DAC will be able to conduct a more comprehensive assessment and better aid in the resolution of disputes between the insurer and claimant. The **OCF-11A** form replaces the need for covering letters from the insurer. Insurers and claimants have been instructed by the Superintendent of Financial Services **not** to use covering letters as they may contain information or statements that are irrelevant to the assessment process.

If a covering letter is forwarded, the DAC will share the correspondence with the other party, pursuant to the DAC General Guideline #4.

The neutrality of DACs is critical. By using the **OCF-11A** form, DACs will be able to maintain their objectivity in completing unbiased, comprehensive assessments in a transparent process to assist both parties.

The Summary Report, referred to as the **OCF-11B**, will be completed by the DAC. A completed assessment report will contain the **OCF-11A** (basic information), the **OCF-11B** (summary of assessment findings), and the assessment reports with signatures of the primary assessors.

WHAT IF THE DAC REQUESTS ADDITIONAL INFORMATION?

To avoid delays at the referral stage of the process, insurance companies are encouraged to confirm with the DAC that all relevant and up-to- date information necessary to complete the assessment has been included.

There may be cases where, in the opinion of the DAC, the referral package is incomplete or relevant information is missing. In these cases, the DAC should follow the procedures found in the DAC General Guideline #4 to communicate any deficiency to both parties (the insurance company and the claimant). The DAC may then ask them to provide the missing information, and advise them that the assessment process could be delayed depending upon the nature of the missing information.

If the DAC can acquire this missing information more quickly than the parties, the DAC may assume responsibility for gathering information directly, provided it does so with the consent and authorization of the parties.

WHAT HAPPENS AFTER YOU HAVE COMPLETED THE DAC ASSESSMENT?

After the DAC has looked at the case in detail, it will write a report explaining *clearly* how the assessment was conducted, the results of the assessment, and what the DAC concludes about the case *and the reasons* for its opinion.

The DAC Guidelines require a final, written report be produced at the end of an assessment. No partial reports are permitted. That is, if there are a number of parts to an assessment plan, and for some reason *all* scheduled parts have yet to be completed, no final written report can be produced. In such circumstances, the DAC must provide both parties written reasons why the assessment plan was not completed, and confirm that no final report will be produced until the entire assessment plan is completed.

Please note that the only time a DAC is permitted to issue an addendum to a DAC report is for clarifi-

cation of the DAC findings, to correct an error in the original DAC report, or to deal with an omission in the DAC report. If new information emerges and the parties agree that the review of the *new* material may alter the DAC's opinion, then a new DAC assessment should be arranged. Neither party should request an "updated" report from the DAC.

Where the parties disagree with either the outcome of the DAC or the impact of any new information on the original DAC findings, either party may choose to apply for mediation with the Dispute Resolution Group of the Financial Services Commission of Ontario.

WHAT DO YOU DO IF YOU HAVE A COMPLAINT ABOUT A DAC?

The DAC Committee has established a process to deal with complaints regarding DACs that fail to conduct assessments in accordance with the Operational Procedures, General Guidelines and Assessment Protocols.

The objective of the complaint management process is to resolve systemic problems giving rise to a complaint rather than to sanction specific DACs.

The Accident Benefits Analysis Unit (ABAU), under the guidance of the DAC Committee's Operations Subcommittee, will review complaints related to:

- Compliance with principles of neutrality and unbiased behaviour throughout the entire DAC assessment process, including the DAC Report;
- Compliance with conflict of interest rules;
- Compliance with the General Guidelines, Operating Procedures and Assessment Protocols; and
- Compliance with capacity and service requirements.

The Operations Subcommittee and the ABAU cannot review complaints that fall outside its jurisdiction, including complaints relating to the business practices of an insurer, the professional conduct of a health care provider or complaints concerning the outcome of a DAC Report.

The Complaint & Discipline Protocol establishes standards of fairness for managing complaints and outlines the process and relevant time lines involved in each stage of investigation and the imposition of sanctions.

All complaints concerning DACs must be directed to the ABAU in writing. The ABAU will review the complaint to ensure jurisdiction and determine the extent of involvement required of the Operations Subcommittee. Follow-up actions and sanctions imposed on DACs range from remedial actions such as providing education to the parties, peer monitoring, developing and implementing corrective action plans and regular site visits, to more serious actions such as removing a DAC from the roster.

WHAT IF THE CLAIMANT AND INSURER STILL CANNOT RESOLVE THEIR DISAGREEMENT?

If the claimant and insurer still cannot resolve their disagreement after getting the DAC's report, either party can apply for mediation at the Financial Services Commission of Ontario to assist in resolving the dispute.

HOW CAN I GET MORE INFORMATION?

The DAC Committee and the ABAU continue to focus their efforts on resolving the systemic problems that undermine the founding principles of the DAC system. **General Guidelines** are issued to address specific issues that impact on the neutrality and accessibility of the DAC system. The four General Guidelines issued to date are General Guidelines 1: Use of Surveillance in DAC Assessments, General Guidelines 2: Production Requests, General Guidelines 3: Permission to Disclose Health Information to the DAC Centre, General Guidelines 4: Ensuring Neutrality in the Designated Assessment Centre System and General Guideline 5: Conflict of Interest and Nearest DAC.

It is not the intent of these General Guidelines to introduce measures which further complicate the process. Through clarification and education of existing guidelines, the DAC Committee hopes the DAC system will function more efficiently and with better transparency.

Information Communiques are issued quarterly to keep the DAC abreast of current issues and enable the DAC Committee to provide direction to the DACs on how they should approach issues and problems as they arise in their daily operations.

The **Assessment Guides** address the "nuts and bolts" issues of operating a DAC centre and are the technical documents that dictate how DACs are to complete their assessments, such as the time lines that DACs must adhere to.

If you want copies of any published DAC material, including an up-to-date roster of DACs, please visit the Commission's website at **www.fsco.gov.on.ca**

SECTION D – FEES AND ASSESSMENTS

1. Fees ..... D 1-1
2. Insurer Assessment ..... D 1-1
3. Payment of Fees – By the Insured Person ..... D 1-2
4. Payment of Fees and Insurer Assessment – By the Insurer ..... D 1-2

FEES AND ASSESSMENTS

1. **Fees** - ***(An application filing fee is charged to the party that initiates an arbitration, an appeal or a variation/revocation proceeding.)***

1.1 The application filing fee for an arbitration is **$100**. Only insured persons can file an ***Application for Arbitration.***

1.2 The application filing fee for an appeal of an arbitration order is **$250**. Either an insured person or an insurer can file a ***Notice of Appeal*** of an arbitration order.

1.3 The application filing fee for a variation/revocation of an arbitration or appeal order is **$250**. Either an insured person or an insurer can file an ***Application for Variation/Revocation.***

1.4 The fee for photocopies of a document from the Commission is **$0.50** per page with a **$5** minimum.

1.5 The fee for handling a cheque returned to the Commission as having insufficient funds is **$35**.

2. **Insurer Assessment** - ***(An assessment is charged to an insurer that is a named party to an arbitration, an appeal or a variation/revocation proceeding.)***

2.1 The insurer assessment charged to an insurer that is named as a party to an arbitration proceeding after March 31, 1997 where an arbitrator is appointed without a neutral evaluation being commenced at the Commission is **$3,000.** The insurer assessment is triggered by the Commission on the due date for filing the ***Response by Insurer to an Application for Arbitration*** **(FORM E).** The insurer assessment will not be charged where the Commission has received written confirmation that all issues in dispute in the arbitration proceeding have been resolved, provided that the written confirmation is received by the Commission prior to the due date for filing the ***Response by Insurer to an Application for Arbitration***.

2.2 The insurer assessment charged to an insurer that is named as a party to an arbitration after March 31, 1997 where a neutral evaluation is commenced at the Commission is **$1,000**. The insurer assessment is triggered by the Commission upon receipt of a completed ***Agreement to Neutral Evaluation at the Commission*** **(FORM D)**.

2.3 The insurer assessment charged to an insurer where an arbitrator has been appointed to conduct a hearing after the termination or completion of a neutral evaluation conducted at the Commission and the insurer has been assessed the **$1,000** referred to in 2.2 is **$2,000.** This insurer assessment is triggered when the Neutral Evaluation is terminated or withdrawn or when the **Report of the Neutral Evaluator** is issued and settlement of the issues in dispute is not confirmed in writing within two days of the issuance of the Report.

2.4 The insurer assessment charged to an insurer that is named as a party to an appeal is **$500.**

2.5 The insurer assessment charged to an insurer that is named as a party to a variation/revocation proceeding is **$500.**

2.6 Where there are two insurers named in a proceeding, both insurers must pay assessments. Insurer assessments are not refundable except as outlined under subparagraph 2.8.

2.7 Where a proceeding is consolidated with another proceeding, the insurer will be assessed only once.

2.8 Arbitration assessments may not be assessed to an insurer **before** the due date for filing the ***Response by Insurer to an Application for Arbitration*** **(FORM E)** as set out in 2.1 or when an arbitrator has determined by order that there is no jurisdiction to decide the case (for example, expired time limits).

3. Payment of Fees - *By the Insured Person*

3.1 An insured person must pay the fees outlined above in 1.1, 1.2, and 1.3, at the time of filing their application(s).

3.2 All fees must be paid by cash (in person only), cheque, or money order. Do not send cash through the mail.

3.3 All cheques and money orders must be made payable to the order of the **MINISTER OF FINANCE**.

3.4 Filing fees may not be waived under the *Insurance Act*, the *Financial Services Commission of Ontario Act, 1997*, or Ontario Regulations.

3.5 Payment of filing fees may not be deferred under the *Insurance Act*, the *Financial Services Commission of Ontario Act, 1997*, or Ontario Regulations.

3.6 Filing fees will not be refunded by the Commission but may be recovered as part of an applicant's expenses under the *Insurance Act*, the *Financial Services Commission of Ontario Act, 1997*, or Ontario Regulations.

4. Payment of Fees and Insurer Assessment - *By the Insurer*

4.1 The Commission will invoice insurers on a quarterly basis for the fees outlined above in 1.2 and 1.3 and the insurer assessments outlined above in 2.1, 2.2, 2.3, 2.4 and 2.5. The invoice will provide each insurer with an accounting of the fees and assessments charged to their company for that quarter.

4.2 The Dispute Resolution charges (as outlined in 4.1) will be combined with the regular assessment for Commission costs for those insurers who pay the regular assessment on a quarterly basis.

SECTION E – SETTLEMENT REGULATION

Excerpt from Regulation 664, R.R.O. 1990, as amended by
O. Reg. 780/93 made under the *Insurance Act*, Subsection 9.1
(Settlements – Statutory Accident Benefits) ..... E - 1

EXCERPT FROM REGULATION 664, R.R.O. 1990, AS AMENDED BY ONTARIO REGULATION 780/93 MADE UNDER THE *INSURANCE ACT*

SETTLEMENTS - STATUTORY ACCIDENT BENEFITS

9.1 (1) In this section, "settlement" means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule.*

(2) Before a settlement is entered into between an insurer and an insured person, the insurer shall give the insured person a written notice that contains the following:

1. A description of the benefits that may be available to the insured person under the *Statutory Accident Benefits Schedule* and any other benefits that may be available to the insured person under a contract of automobile insurance.

2. A description of the impact of the settlement on the benefits described under paragraph 1, including a statement of the restrictions contained in the settlement on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act.

3. A statement that the insured person may rescind the settlement within two business days after the settlement is entered into by delivering a written notice to the insurer.

4. A statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 1.

5. If the settlement provides for the payment of a lump sum in an amount offered by the insurer and, with respect to a benefit under the Statutory Accident Benefits Schedule that is not a lump sum benefit, the settlement contains a restriction on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act, a statement of the insurer's estimate of the commuted value of the benefit and an explanation of how the insurer determined the commuted value.

6. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

(3) A settlement may be rescinded by the insured person, within two business days after the settlement is entered into, by delivering a written notice to the insurer.

(4) If the insurer did not comply with subsection (2), the insured person may rescind the settlement after the period mentioned in subsection (3) by delivering a written notice to the insurer.

(5) A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act is not void under subsection 279(2) of the Act if,

(a) the restriction is contained in a settlement; and

(b) the insurer complied with subsection (2). O.Reg.780/93, s.7.

SECTION F – EXPENSE REGULATION

Excerpt from Regulation 664, R.R.O. 1990, as amended by
O. Reg. 464/96 made under the *Insurance Act*, Subsection 12
(Criteria for Awarding Expenses) ..... F - 1

Schedule to Regulation 664, R.R.O. 1990, as amended by
O. Reg. 464/96 (Dispute Resolution Expenses) ..... F - 1

EXCERPT FROM REGULATION 664, R.R.O. 1990, AS AMENDED BY ONTARIO REGULATION 464/96 MADE UNDER THE *INSURANCE ACT*

12. (1) The expenses set out in the Schedule are prescribed for the purpose of subsection 282(11) of the Act.

(2) An arbitrator may award expenses to an insurer or insured person under subsection 282 (11) of the Act if the arbitrator is satisfied that the award is justified, having regard to the following criteria:

1. Each party's degree of success in the outcome of the proceeding.

2. Conduct of the insurer or the insured person that tended to shorten or facilitate the proceeding or that tended to prolong, obstruct or hinder the proceeding, including failure to comply with undertakings or orders.

3. Whether the proceeding or any position taken by the insurer or the insured person during the proceeding was manifestly unfounded, frivolous, vexatious, fraudulent or an abuse of process.

4. The degree of complexity, novelty or significance of the factual or legal issues raised in the proceeding.

5. If the insurer or the insured person requests, any written offers to settle made after the conclusion of mediation and before the conclusion of the arbitration in accordance with the rules of practice and procedure applicable to the proceeding, including the terms of the offers, the timing of the offers and the responses to the offers, having regard to the result of the proceeding.

6. Any other matter related to the proceeding that the arbitrator considers relevant to the issue of whether an award of expenses is justified.

SCHEDULE

DISPUTE RESOLUTION EXPENSES

(Subsection 282 (11) of the Act)

1. The filing fees paid by the insured person when applying for arbitration may be awarded to the insured person.

2. The filing fees paid by the insured person or the insurer when appealing the order of an arbitrator or applying to vary or revoke an order may be awarded.

3. (1) The legal fees payable by the insured person or the insurer for the following matters may be awarded:

1. For all services performed before an arbitration, appeal, variation or revocation hearing.

2. For the preparation for an arbitration, appeal, variation or revocation hearing.

3. For attendance at an arbitration, appeal, variation or revocation hearing.

4. For services subsequent to an arbitration, appeal, variation or revocation hearing.

(2) The number of hours for which legal fees may be awarded shall be determined by the arbitrator, having regard to the criteria set out in subsection 12 (2) of this Regulation.

(3) The maximum amount that may be awarded for legal fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission or Financial Services Commission of Ontario, as it may be amended from time to time.

3.1 (1) The agent's fees payable by the insured person or the insurer for the following matters may be awarded:

1. For the preparation for an arbitration, appeal, variation or revocation hearing.

2. For attendance at an arbitration, appeal, variation or revocation hearing.

3. For services subsequent to an arbitration, appeal, variation or revocation hearing.

(2) The maximum amount that may be awarded for agent's fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission or Financial Services Commission of Ontario, as it may be amended from time to time.

4. The amount of the following disbursements made by or on behalf of the insured person or the insurer may be awarded:

1. For long distance telephone, facsimile and other telecommunication charges.

2. For typing, printing and reproducing copies of documents.

3. For the delivery, by mail or courier, of items relating to the arbitration, appeal, variation or revocation hearing.

4. For other out-of-pocket expenses incurred in furtherance of the arbitration, appeal, variation or revocation hearing.

5. Any applicable taxes paid in respect of the expenses referred to in this section.

5. (1) The amount of the following witness fees paid by or on behalf of the insured person or the insurer may be awarded:

1. For the attendance of witnesses, in accordance with subsection (2).

2. For the attendance of an expert witness who gives opinion evidence at the arbitration or hearing or whose attendance is necessary, in accordance with subsection (3).

3. For a report prepared by an expert, provided to the other parties to the arbitration or hearing and necessary for the conduct of the arbitration or hearing, in accordance with subsection (4).

(2) The maximum amount that may be awarded for the attendance of a witness is the amount of the attendance allowance for the witness that may be allowed under Rule 58.05 of the rules of court as a disbursement.

(3) The maximum amount that may be awarded for the attendance of an expert witness is $200 per hour of attendance, up to a maximum of $1,600 per day.

(4) The amount of the expenses paid by or on behalf of the insured person or the insurer to an expert witness for preparation for a hearing at which the witness testifies may be awarded, to a maximum of $500.

(5) The amount of the expenses paid by or on behalf of the insured person or the insurer to an expert for the preparation of a report may be awarded, to a maximum of $1,500.

6. (1) The amount of the following expenses paid by or on behalf of the insured person, the insured person's lawyer or agent, the insured person's attendant, if one is required, or the insurer's lawyer or agent may be awarded:

1. For travelling expenses, in accordance with subsection (2).

2. For overnight accommodation and meals, in accordance with subsection (3).

(2) The maximum amount of travelling expenses that may be awarded for a person,

(a) for an arbitration or a hearing that takes place in the municipality in which the person resides is the amount incurred by the person for each day of his or her necessary attendance at the arbitration or hearing;

(b) for an arbitration or a hearing that takes place outside the municipality in which the person resides and within 300 kilometres of his or her residence is the lesser of,

(i) 30 cents per kilometre for one return trip between the person's residence and the place in which the arbitration or hearing takes place, or

(ii) the amount incurred by the person;

(c) for an arbitration or a hearing that takes place 300 or more kilometres from the person's residence is the lesser of,

(i) the amount of the return economy airfare for the person plus 30 cents per kilometre for one return trip between his or her residence and the airport and for one return trip between the airport and the place of the arbitration or hearing, or

(ii) the amount incurred by the person.

(3) The maximum amount that may be awarded for overnight expenses and meals is $150 per night for each overnight stay required for the person. R.R.O. 1990, Reg. 664, Schedule.

SECTION G – FORMS

Form A – Application for Mediation

Form B – Response to an Application for Mediation

Form C – Application for Arbitration

Form D – Agreement to Neutral Evaluation at the Commission

Form E – Response by Insurer to an Application for Arbitration

Form F – Statement of Service

Form G – Reply by the Applicant for Arbitration

Form H – Joint Statement for Neutral Evaluation at the Commission

Form I – Notice of Appeal

Form J – Response to Appeal

Form K – Application for Intervention

Form L – Application for Variation/Revocation

Form M – Response to Application for Variation/Revocation

Form N – Summons to Witness

Form O – Affidavit of Service for a Summons to Witness

Financial Services Commission of Ontario

Dispute Resolution Group

Application for Mediation
Form A

Use this application form after a motor vehicle accident, when a dispute arises about whether the claimant qualifies for benefits under the *Statutory Accident Benefits Schedule ("SABS")* and how much those benefits should be. Mediation is an informal process in which a neutral third party (the mediator) helps the parties resolve the issues in dispute. The mediator works with the parties to find resolutions that are acceptable to everyone involved. There is no cost to the injured person for mediation. The benefits that can be mediated are described in this booklet.

Before filing an application for mediation, the parties or their representatives should contact each other to identify the issues in dispute, clarify the facts, exchange documents relevant to the dispute and discuss settlement. Parties are expected to take part personally in the mediation process and to be available during the 60-day mediation period.

After completing the application, return it to the Financial Services Commission of Ontario (the "Commission") at the address below.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

If you have any questions about this application, or want more information, contact:

Mediation Services
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor, Box 85
North York ON M2N 6L9

In Toronto: (416) 250-6714, extension 7210

Toll Free: 1-800-517-2332, extension 7210

Fax: (416) 590-7077

Mediation Hotline: (416) 590-7210

Commission website: www.fsco.gov.on.ca

Instructions, page 1

Ce formulaire est également disponible en français.

1974 (03/01)

Please print. Read the instructions carefully. To complete the application more easily, remove the section you are filling out and place it beside the relevant instructions.

For a complete set of the rules about mediation, refer to the Dispute Resolution Practice Code.

How to complete the Application

SECTION 1

This section must be completed no matter what date the motor vehicle accident occurred.

General Information

Please answer all questions. Note that if you prefer a language other than English or French, it is up to you to make arrangements and pay the cost for your own interpreter.

Claimant

For the purposes of this application, a claimant is any person making a claim for statutory accident benefits to an insurance company as a result of a motor vehicle accident. The claimant is not necessarily the motor vehicle insurance policyholder. Fill in the name and address of the claimant and provide telephone numbers so that we can contact the claimant without delay to discuss the dispute. A minor is anyone under the age of 18.

Claimant's Representative

If the claimant will be represented in mediation by someone else, fill in the name, title, firm name, address and telephone numbers so that we can contact the representative to discuss the dispute. Please include your file reference number, if any. Complete the question concerning the relationship of the representative to the claimant. **The claimant must provide full authorization to the representative to discuss all issues in dispute, to negotiate and to enter into agreements or a settlement of any and all issues in dispute.**

Insurance Company

Fill in the full name of the insurance company and the person you have been dealing with at the insurance company. Please provide the name of the policyholder, the policy number and the claim number.

Insurance Company's Representative

If you are filing on behalf of the claimant, please leave this blank. However, if you are the insurer, please provide the name of the insurance company's representative, the representative's title, firm name, address, telephone numbers and file reference number. **The insurance company's representative must be authorized to settle the dispute on behalf of the insurance company.**

Signature and Certification

The claimant **must** sign and date the bottom of Section 1. We will not accept an application unless it is signed by the claimant, the insurance company or an authorized representative. Please read the declaration before signing. After completing the application, make two copies. Keep one copy for yourself and send the original application plus a copy to Mediation Services at the Commission. The address is on the front page of this application. You should attach a copy of any information about your dispute. For example: the insurance company's written explanation of why it denied the benefit; doctor's reports; tax returns; and financial statements.

SECTIONS 2, 3, 4

This application form is designed to accommodate 3 different Statutory Accident Benefits Schedules.

You need to complete only ONE of these sections depending on the date of the motor vehicle accident. Discard unused sections.

***Section 2 – Complete if the motor vehicle accident occurred on or after* November 1, 1996.**

Section 3 – Complete if the motor vehicle accident occurred on or between* January 1, 1994 *and* October 31, 1996, *inclusive.

Section 4 – Complete if the motor vehicle accident occurred on or between* June 22, 1990 *and* December 31, 1993, *inclusive.

SECTION 5 – Documents at the Mediation

The claimant must complete Section 5. List key documents in the claimant's possession to which reference will be made in the mediation. Also list key documents that the claimant wishes to obtain from other sources including the other party to the mediation, for the purpose of discussing settlement.

Steps in the Mediation Process

Step 1

Return the following items to Mediation Services at the Commission. The full address is on the front of this form.

- Two copies of the completed *Application for Mediation*, signed and dated (keep one copy for yourself).
- A copy of the insurance company's written explanation of why they denied the benefit, if available.
- Any information about your dispute that is relevant (i.e., doctor's reports, tax receipts or financial statements). **Send copies only – keep originals of all your documents.**

Failure to comply with all these instructions will result in your application being returned to you.

Step 2

The Commission will review your application for completeness and will contact you if additional information is required before appointing a mediator. The Commission may reject the application for deficiencies or jurisdictional concerns. Once complete, your application will be forwarded to the other party along with a *Response to an Application for Mediation* form and a mediator will be appointed. The other party will provide the completed Response form to you and the Commission. A letter will be sent notifying you of the name of the mediator.

Step 3

When you receive this letter you should immediately contact the mediator to discuss the issues in dispute and to arrange for a mediation meeting if appropriate. You are requested to produce and exchange all relevant documents and reports ***before*** the mediation meeting.

Step 4

In cases where there is a mediation date set, you will participate in person or by teleconference as the mediator considers appropriate. Appointing a representative does not relieve any party of the obligation to participate in the mediation.

Step 5

At the end of the mediation period, the mediator will produce a report indicating the disputed issues discussed and the outcome of the mediation. The Commission will deliver a copy of the *Report of Mediator* to the parties.

For additional information concerning the mediation process please refer to the *Dispute Resolution Practice Code* and the Commission's website at *www.fsco.gov.on.ca*

Note: You may settle your dispute with the other party directly at any time during the mediation process. Please notify Mediation Services of any settlement.

Instructions, page 3

Form A
Application for Mediation

SAMPLE APPLICATION

Description of Dispute

Check the box beside the benefits you are disputing. Please refer to *Available Benefits* in the Instructions, page 5, for a description of the types of statutory accident benefits available. Give the details of the dispute and state the amount that is in dispute, if possible. **Be as specific as possible when you are explaining your reasons for mediation.** List the details of each claim separately. Describe what was claimed, what was paid, what was denied and when.

If you need more space, attach extra sheets.

		For each benefit checked, briefly explain the details of the dispute *(Attach extra sheets if necessary.)* ▼
[X] **Weekly Benefits**	Which weekly benefit are you disputing? [X] income replacement [ ] non-earner What are you disputing? [ ] initial entitlement to benefits [X] length of time benefits were paid [ ] amount of weekly benefits [ ] entitlement to benefits past 104 weeks [ ] benefits after age 65 [ ] other, specify ▼ If you received income benefits, state weekly amount and duration of payments. $ 300.00 From Jan. 8, 1999 To May 14, 1999 Is the insurance company claiming a repayment of benefits? [X] No [ ] Yes If Yes, amount ▼ $	I remain unable to return to work as a result of my motor vehicle accident. I am unable to perform the physical requirements of my job. I am enclosing the doctor's report and the insurance company's notice terminating benefits.
[X] **Medical Benefits**	Amount in dispute? $ 350.00 ($35/week for 10 weeks) Does this claim involve catastrophic impairment? [X] No [ ] Yes	My doctor recommended chiropractic treatments at the ABC Clinic. I had 10 sessions from Feb. 1, 1999 to April 1, 1999. The insurer has refused to pay the expense. Attached is the insurance company's assessment form.
[X] **Interest**	Amount in dispute? Set out calculations. $ 2% per month from May 14th, 1999 to date on amount of $300 per week.	My insurance company hasn't paid weekly benefits since May 14, 1999, and I claim interest on the money that they owe me.

Available Benefits

The types of benefits available, the minimum and maximum available and the rules to qualify for benefits may be different depending on the date of the motor vehicle accident. Complete only the section which relates to the date of the accident.

The following benefits are available for motor vehicle accidents that occurred on or after November 1, 1996.

Income Replacement Benefits pay a claimant for lost income.

Non-Earner Benefits pay a claimant if he/she suffers a complete inability to carry on a normal life and does not qualify for income replacement or caregiver benefits.

Caregiver Benefits pay a claimant if he/she cannot continue as the main caregiver for a member of their household who is under 16 years of age, or who is over 16 years of age and who requires care because of a physical or mental incapacity.

Medical Benefits pay for reasonable and necessary medical expenses required because of the claimant's injuries. These are expenses that are not covered by any other medical coverage plan such as Ontario Health Insurance or supplementary insurance plans at the claimant's workplace.

Rehabilitation Benefits pay for reasonable and necessary rehabilitation expenses that are required because of the claimant's injuries and are not covered by any other insurance plan.

Attendant Care Benefits pay a claimant for the expense of an aide or attendant, or services provided by a long term care facility.

Case Manager Services Benefits pay for reasonable and necessary expenses related to coordination of goods and services if the claimant sustained a catastrophic impairment as a result of the accident.

Other Expenses (compensation for other pecuniary losses) pay for other reasonable expenses such as the cost of visiting a claimant during treatment or recovery. It also pays for home maintenance and housekeeping services, repairing or replacing items lost or damaged in the accident and lost educational expenses.

Death Benefits pay money to survivors of a person who dies as a result of the accident.

Funeral Expenses pay for funeral expenses of a person who dies as a result of the accident.

The following benefits are available for motor vehicle accidents that occurred on or between January 1, 1994 and October 31, 1996 inclusive.

Income Replacement Benefits pay a claimant for lost income.

Education Disability Benefits pay a claimant if he/she is unable to continue his/her education or to carry out normal daily activities. It also covers a claimant who completed their education less than one year before the accident, but is unable to get a job matching their education or training.

Caregiver Benefits pay a claimant if he/she cannot continue as the main caregiver for a member of their household who is under 16 years of age, or who is over 16 years of age and who requires care because of a physical or mental incapacity. It also covers a caregiver who cannot carry on his or her normal daily activities.

Loss of Earning Capacity Benefits replace the above weekly benefits after two years. It provides income to a claimant who has a long term reduction in their ability to earn income as a result of an accident.

Other Disability Benefits pay a claimant if he/she cannot carry out normal daily activities and does not qualify for a Weekly Income Replacement Benefit, Education Disability Benefit or Caregiver Benefit.

Supplementary Medical Benefits pay for reasonable medical expenses required because of the claimant's injuries. These are expenses that are not covered by any other medical coverage plan such as Ontario Health Insurance or supplementary insurance plans at the claimant's workplace.

Rehabilitation Benefits pay for reasonable rehabilitation expenses that are required because of the claimant's injuries and are not covered by any other insurance plan.

Attendant Care Benefits pay a claimant for the expense of an aide or attendant.

Other Expenses (compensation for other pecuniary losses) pay for other reasonable expenses such as the cost of visiting a claimant during treatment or recovery. It also pays for care for dependants, home maintenance and housekeeping services and repairing or replacing items lost or damaged in the accident.

Death Benefits pay money to survivors of a person who dies as a result of the accident.

Funeral Expenses pay for funeral expenses of a person who dies as a result of the accident.

The following benefits are available for accidents that occurred on or between June 22, 1990 and December 31, 1993 inclusive.

Weekly Benefits pay a claimant for lost income. It also covers a claimant who cannot carry out normal daily activities.

Caregiver Benefits pay a claimant if he/she cannot continue as the main caregiver for a member of their household who is under 16 years of age, or who is over 16 years of age and who requires care because of a physical or mental incapacity.

Supplementary Medical and Rehabilitation Benefits pay for reasonable medical and rehabilitation expenses required because of the claimant's injuries. These are expenses that are not covered by any other medical coverage plan such as Ontario Health Insurance or supplementary insurance plans at the claimant's workplace.

Care Benefits pay a claimant for the expense of an aide or attendant.

Death Benefits pay money to survivors of a person who dies as a result of the accident.

Funeral Expenses pay for funeral expenses of a person who dies as a result of the accident.

Instructions, page 5

Ontario

Financial Services Commission of Ontario

Dispute Resolution Group

Application for Mediation

Form A

Commission file number

Section 1 This section MUST be completed.

General Information

1. What was the date of the motor vehicle accident? Month | Day | Year

2. Who is making this application?
☐ Claimant ☐ Claimant's representative ☐ Insurance company ☐ Insurance company's representative

3. Have you applied for mediation before?
☐ No ☐ Yes

4. Language preferred
☐ English ☐ French ☐ Other, specify ▶

5. Have you contacted the other party and tried to settle the dispute before applying for mediation?
☐ No ☐ Yes

Claimant

Last name | First name | Middle name

☐ Mr. ☐ Mrs ☐ Ms.

Street address | City | Province | Postal Code

Home phone number ( ) | Work phone number ( ) | Fax number ( ) | Birthdate Month | Day | Year

1. What is the best way to reach you?
☐ phone ☐ mail ☐ fax ☐ through my representative

2. Where is the best place to reach you?
☐ home ☐ work ☐ other, specify ▶

3. When is the best time to reach you? Specify days of the week and time

4. Is the Claimant under a legal disability (a minor or mentally incapable)?
☐ No ☐ Yes If Yes, has a family member, or guardian, or court appointed guardian, been named? ☐ No ☐ Yes

Claimant's Representative

Last name | First name | File reference number

☐ Mr. ☐ Mrs ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to the insured person

☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator/ trustee ☐ court appointed guardian ☐ other, specify ▶

Form A
Application for Mediation

Section 1 *continued*

Insurance Company

Company name

Claim representative name | Claim number

Policyholder name | Policy number

Insurance Company's Representative

Last name | First name | File reference number

☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Mediation

1. Do you wish the mediation to be conducted in French?
   ☐ No ☐ Yes

2. Will you require the services of an interpreter at the mediation?
   ☐ No ☐ Yes If Yes, what language? ▶
   Please note that it is up to the Claimant to arrange interpretation or translation during the mediation in languages other than English or French.

3. Do you wish a face-to-face meeting with the other party?
   ☐ No ☐ Yes
   Please note that it is within the mediator's discretion to conduct the mediation by telephone conference.

Signature and Certification

I certify that all information in this Application and attachments is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to Mediation Services of the Commission. I realize that information filed with this Application may be given to the other party in this dispute.

Claimant name (please print) | Claimant Signature
X

Representative name (please print) | Representative Signature
X

Date

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Application.

I certify that my representative ▼

has full authorization as described above

Claimant Signature

Date

1974 (03/01)

ISSUES IN DISPUTE

The types of benefits available, the minimum and maximum amounts available and the rules to qualify for benefits may be different depending on when your motor vehicle accident took place. Fill in only that section covering the date of your accident.

You need to complete only ONE of sections 2, 3 or 4. (Discard unused sections.)

Section 2 – Complete if your motor vehicle accident occurred on or after November 1, 1996.

Section 3 – Complete if your motor vehicle accident occurred on or between January 1, 1994 and October 31, 1996, inclusive.

Section 4 – Complete if your motor vehicle accident occurred on or between June 22, 1990 and December 31, 1993, inclusive.

Section 2 Complete this section ONLY for motor vehicle accidents that occurred on or after November 1, 1996.

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Was the Claimant **asked by the insurance company to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s) ▼

Is the Claimant willing to attend a rescheduled I.E. within the next 30 days?

☐ No ☐ Yes If Yes, state available dates ▶

Please note that in some cases, mediation cannot take place until the Claimant has made him/herself reasonably available for an I.E.

2. Was the Claimant **asked by the insurance company to attend an assessment at a D.A.C.** relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s) ▼

Is the Claimant willing to attend a rescheduled D.A.C. assessment within the next 30 days?

☐ No ☐ Yes If Yes, state available dates ▶

Please note that in some cases, mediation cannot take place until the Claimant has made him/herself reasonably available for a D.A.C. assessment.

To what benefit claim was the D.A.C. assessment related?

☐ medical benefits
☐ rehabilitation benefits
☐ attendant care benefits
☐ determination of catastrophic impairment

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

D.A.C. Code

3. Did the Claimant **ask to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

☐ No ☐ Yes If Yes, to what benefits was the assessment related?

☐ disability benefits (income replacement, non-earner or caregiver benefits)
☐ disability benefits past 104 weeks of accident (income replacement or caregiver)
☐ determination of catastrophic impairment

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

Section 2 *continued*

Description of Dispute

Please review the SAMPLE in the Instructions, page 4, before completing this part. Check all benefits that are in dispute. If there is more than one amount in dispute for a particular benefit, state those amounts in the explanation area. *(Add extra sheets, if necessary.)*

Does the Claimant have optional benefits?
☐ No ☐ Yes

For each benefit checked, briefly explain the details of the dispute.
(Attach extra sheets if necessary.) ▼

☐ **Weekly Benefits**

Which weekly benefit are you disputing?
- ☐ income replacement
- ☐ non-earner

What are you disputing?
- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ benefits after age 65
- ☐ other, specify ▼

If the Claimant received income benefits, state weekly amount and duration of payments.
$
From To

Is the insurance company claiming a repayment of benefits?
☐ No ☐ Yes If Yes, amount ▼
$

☐ **Caregiver Benefits**

Weekly amount in dispute?
$
From To

What are you disputing?
- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ other, specify ▼

☐ **Medical Benefits**

Amount in dispute?
$

Does this claim involve catastrophic impairment?
☐ No ☐ Yes

☐ **Rehabilitation Benefits**

Amount in dispute?
$

☐ **Attendant Care Benefits**

Amount in dispute?
$

Section 2 *continued*

For each benefit checked, briefly explain the details of the dispute.
(Attach extra sheets if necessary.) ▼

☐ **Case Manager Services Benefits**

Amount in dispute?

$

☐ **Other Expenses**

Amount in dispute?

$

What are you disputing?

- lost educational expenses
- expenses of visitors
- housekeeping and home maintenance
- damage to clothing, glasses, etc.
- cost of examinations

☐ **Death Benefits**

Amount in dispute?

$

☐ **Funeral Expenses**

Amount in dispute?

$

☐ **Other Disputes**

Amount in dispute?

$

☐ **Interest**

Amount in dispute? Set out calculations.

$

After completing this Section, make sure that you have signed the Application at the end of Section 1, and that you have listed all of your documents in Section 5. Send two copies of Application Sections 1, 2 and 5 plus any extra sheets, to:

Mediation Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Section 3 Complete this section ONLY for motor vehicle accidents that occurred on or between January 1, 1994 and October 31, 1996, inclusive.

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Was the Claimant **asked by the insurance company to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s) ▼

Is the Claimant willing to attend a rescheduled I.E. within the next 30 days?

☐ No ☐ Yes If Yes, state available dates ▶

Please note that in some cases, mediation cannot take place until the Claimant has made him/herself reasonably available for an I.E.

2. Was the Claimant **asked by the insurance company to attend an assessment at a D.A.C.** relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s) ▼

Is the Claimant willing to attend a rescheduled D.A.C. assessment within the next 30 days?

☐ No ☐ Yes If Yes, state available dates ▶

Please note that in some cases, mediation cannot take place until the Claimant has made him/herself reasonably available for a D.A.C. assessment.

To what benefit claim was the D.A.C. assessment related?

☐ supplementary medical benefits
☐ rehabilitation benefits
☐ attendant care benefits
☐ loss of earning capacity benefits

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

D.A.C. Code

3. Did the Claimant **ask to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

☐ No ☐ Yes If Yes, to what benefits was the assessment related?

☐ disability benefits (income replacement, education disability or caregivers benefits)
☐ loss of earning capacity benefits
☐ attendant care benefits

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

Section 3 *continued*

Description of Dispute

Please review the SAMPLE in the Instructions, page 4, before completing this part. Check all benefits that are in dispute. If there is more than one amount in dispute for a particular benefit, state those amounts in the explanation area.

For each benefit checked, briefly explain the details of the dispute.
(Attach extra sheets if necessary.) ▼

☐ **Weekly Benefits**

Which weekly benefit are you disputing?

- income replacement
- education disability
- caregiver
- other disability

What are you disputing?

- initial entitlement to benefits
- length of time benefits were paid
- amount of weekly benefits
- entitlement to benefits past 104 weeks
- benefits after age 65
- other, specify ▼

If the Claimant received income benefits, state weekly amount and duration of payments

$

From To

Is the insurance company claiming a repayment of benefits?

No Yes If Yes, amount ▼

$

Does the Claimant have a Pre-determined income from Self-Employment Agreement?

No Yes

☐ **Loss of Earning Capacity Benefits**

Did the Claimant receive a Loss of Earning Capacity Benefits offer from the insurer?

No If No ▼

Claiming Loss of Earning Capacity Benefits

Yes If Yes ▼

What part(s) of the offer are you disputing?

- Pre-accident earning capacity
- Residual Earning capacity

☐ **Education Disability Benefits (Lump Sum Benefits)**

Amount in dispute?

$

☐ **Medical Benefits**

Amount in dispute?

$

☐ **Rehabilitation Benefits**

Amount in dispute?

$

Section 3 *continued*

For each benefit checked, briefly explain the details of the dispute.
(Attach extra sheets if necessary.) ▼

☐ **Attendant Care Benefits**
Amount in dispute?
$

☐ **Compensation for Other Pecuniary Losses**
Amount in dispute?
$
What are you disputing?
- expenses of visitors
- dependant care expenses
- housekeeping and home maintenance
- damage to clothing, glasses, etc.
- cost of examinations

☐ **Death Benefits**
Amount in dispute?
$

☐ **Funeral Expenses**
Amount in dispute?
$

☐ **Other Disputes**
Amount in dispute?
$

☐ **Interest**
Amount in dispute? Set out calculations.
$

After completing this Section, make sure that you have signed the Application at the end of Section 1, and that you have listed all of your documents in Section 5. Send two copies of Application Sections 1, 3 and 5 plus any extra sheets, to:

Mediation Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Form A
Application for Mediation

Section 4 — Complete this section ONLY for motor vehicle accidents that occurred on or between June 22, 1990 and December 31, 1993.

Insurer Examination (Medical) (I.E.) Information

Was the Claimant **asked by the insurance company to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s). ▼

Is the Claimant willing to attend a rescheduled I.E. within the next 30 days?

☐ No ☐ Yes If Yes, state available dates. ▶

Please note that in some cases, mediation cannot take place until the Claimant has made him/herself reasonably available for an I.E.

Description of Dispute

Please review the SAMPLE in the Instructions, page 4, before completing this part. Check all benefits that are in dispute. If there is more than one amount in dispute for a particular benefit, state those amounts in the explanation area. *(Add extra sheets, if necessary.)*

Do you have optional benefits?

☐ No ☐ Yes

For each benefit checked, briefly explain the details of the dispute. *(Attach extra sheets if necessary.)* ▼

☐ **Income Benefits**

Which income benefit are you disputing?

- ☐ employed benefits
- ☐ benefit if no income

What are you disputing?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 156 weeks
- ☐ other, specify ▼

If the Claimant received weekly income benefits, state amount per week and duration of payments.

$

From To

Is the insurance company claiming a repayment of benefits?

☐ No ☐ Yes If Yes, amount ▼

$

☐ **Childcare Benefits**

What are you disputing?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ other, specify ▼

If the Claimant received weekly Childcare Benefits, state amount per week and duration of payments.

$

From To

Section 4 *continued*		For each benefit checked, briefly explain the details of the dispute. *(Attach extra sheets if necessary.)* ▼
☐ **Supplementary Medical/ Rehabilitation Benefits**	Amount in dispute? $	
☐ **Care Benefits**	Amount in dispute? $	
☐ **Death Benefits**	Amount in dispute? $	
☐ **Funeral Expenses**	Amount in dispute? $	
☐ **Other Disputes**	Amount in dispute? $	
☐ **Interest**	Amount in dispute? Set out calculations. $	

After completing this Section, make sure that you have signed the Application at the end of Section 1, and that you have listed all of your documents in Section 5. Send two copies of Application Sections 1, 4 and 5 plus any extra sheets, to:

Mediation Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Section 5 Document List This section MUST be completed.

It is expected that both parties have exchanged key documents prior to filing this *Application for Mediation*.

(Attach extra sheets if necessary.)

Documents

1. List key documents in your possession to which you will refer in the mediation.
   Identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

Extra sheets attached

2. List key documents not currently in your possession, which you intend to get from other sources (such as employers, doctors, Revenue Canada) for use in the mediation. You should also include any documents requested from the other party (such as Insurer Examination (Medical) reports, surveillance evidence, a summary of benefits paid) which have not yet been provided.
   Wherever possible, identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

Extra sheets attached

After completing this Section, make sure that you have signed the Application at the end of Section 1. Send two copies of Application Sections 1, 5, and ONE of Sections 2, 3, or 4, depending on the accident date, plus any extra sheets, to:

Mediation Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Section 5

1974 (03/01)

Ontario

Financial Services Commission of Ontario

Dispute Resolution Group

Response to an Application for Mediation

Form B

Mediation file number

An *Application for Mediation* has been filed with the Dispute Resolution Group of the Financial Services Commission of Ontario. You are a party in this application. Use this form to respond to the reasons for the dispute.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended. This information will be used in the dispute resolution process for statutory accident benefits. This information will be available to all parties to the mediation. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group.

When you have completed this form, make three copies, keep a copy for yourself, send a copy to the other party in this dispute, and send the original to:

Mediation Services
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor, Box 85
North York ON M2N 6L9

If you have any questions about this form, or want more information, contact the Commission in Toronto at:

(416) 590-7210

or toll free at 1-800-517-2332, ext 7210.

Commission website: www.fsco.gov.on.ca

Claimant

For the purposes of this Response, a Claimant is any person making a claim for statutory accident benefits to an insurance company as the result of a motor vehicle accident. The Claimant is not necessarily the motor vehicle insurance policyholder.

Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Street address | City | Province | Postal Code

Home phone number ( ) | Work phone number ( ) | Fax number ( ) | Birthdate: Month / Day / Year

1. What is the best way to reach you?

☐ phone ☐ mail ☐ fax ☐ through my representative

2. Where is the best place to reach you?

☐ home ☐ work ☐ other, specify ▶

3. When is the best time to reach you? Specify days of the week and time.

4. Is the Claimant under a legal disability (a minor or mentally incapable)?

☐ No ☐ Yes If Yes, has a family member, or legal guardian, or court appointed guardian, been named? ☐ No ☐ Yes

Insurance Company

Company name | Claims representative

Insurer's claim number | Policyholder name | Policy number

Respondent's Representative

Last name | First name | File reference number

☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to Respondent

☐ lawyer ☐ paralegal ☐ other, specify ▶

Ce formulaire est également disponible en français.

1849 (03/01)

Form B

Response to an Application for Mediation

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Was the Claimant **asked by the insurance company to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s). ▼

Is the insurer willing to arrange a new appointment within the next 30 days?

☐ No ☐ Yes If Yes, state available dates. ▶

Please note that in some cases, mediation cannot take place until a Claimant has made him/herself reasonably available for an I.E.

To what benefits does the I.E. relate?

2. Was the Claimant **asked by the insurance company to attend an assessment at a Designated Assessment Centre (D.A.C.)** relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Claimant attend? ▶ ☐ No ☐ Yes If No, give reason(s). ▼

Is the insurer willing to arrange a new appointment within the next 30 days?

☐ No ☐ Yes If Yes, state available dates. ▶

Please note that in some cases, mediation cannot take place until a Claimant has made him/herself reasonably available for a D.A.C. assessment.

To what benefits does the D.A.C. relate?

Date(s), name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

3. Did the claimant **ask to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

☐ No ☐ Yes If Yes, to what benefits does the D.A.C. relate?

Date(s), name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Form B

Response to an Application for Mediation

Response Respond to each issue raised in the *Application for Mediation* and identify any new issues that you wish to raise at mediation. *Attach extra sheets if necessary.*

☐ Extra sheets attached

Document List – this section MUST be completed.

It is expected that both parties have exchanged key documents prior to filing this *Response to an Application for Mediation.* ***Attach extra sheets if necessary.***

List all available documents (medical reports, etc.) that the Respondent intends to refer to at mediation. Identify the type of document (letter, medical report, tax return) with the name of the writer or issuing institution and date of the document.

☐ Extra sheets attached

List key documents not currently in your possession, which the Respondent intends to get from other sources (such as employers, doctors, Revenue Canada), which are required for discussing a settlement of the issues in dispute. The Respondent should also include any documents requested from the other party which have not yet been provided. *Wherever possible identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.*

☐ Extra sheets attached

Signature

Name *(please print)*	Title	Signature	Date

COMMISSION USE ONLY

Insurance company / Lawyer code	Date received	Date registered	File number
Mediator	**Caseworker**	**Assistant**	**Assistant**

Sample

Financial Services Commission of Ontario

Dispute Resolution Group

Application for Arbitration
Form C

An insured person may use this form to apply for arbitration of disputes about entitlement to or the amount of benefits under the *Statutory Accident Benefits Schedule (SABS)*. You can apply for arbitration only if the issues in dispute have not been resolved through mediation. **You may also use this form to apply for Neutral Evaluation.**

After you complete the application, **keep one copy** for yourself and **return two copies** of the completed application form signed by you, along with relevant documents and the filing fee, to Arbitration Services at the Financial Services Commission of Ontario (the "Commission") at the address below.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

You must enclose an application fee of $100. Make your cheque or money order payable to the Minister of Finance. Cheques made out to the Commission cannot be accepted and will be returned. Failure to pay the application fee will result in the Commission returning your application to you.

If you have any questions about this application, or want more information, contact:

Arbitration Services
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
North York ON M2N 6L9

In Toronto: (416) 250-6714, extension 7202

Toll Free: 1-800-517-2332, extension 7202

Fax: (416) 590-8462

Arbitration Hotline: (416) 590-7202

Commission website: www.fsco.gov.on.ca

Ce formulaire est également disponible en français.

1850 (03/01)

Sample

Applying for Arbitration

For a complete set of the rules about Arbitration and Neutral Evaluation, refer to the Dispute Resolution Practice Code.

How to Complete the Form

PLEASE PRINT

SECTION 1

General Information

Answer all six questions.

Applicant

Fill in your name, address and phone numbers, and tell us the best place to reach you. Be sure to fill in the mediation file number. You can find the mediation file number on the front of the Mediator's Report.

Applicant's Representative

You may choose to have someone represent you. Although many people are represented by a lawyer during arbitration or Neutral Evaluation, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. *If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the arbitration and can settle the dispute on your behalf. A minor (a person under the age of 18) or a person who has been declared mentally incapable, must have a representative.*

Insurance Company

Fill out the name of the insurance company and a contact or representative if known. Please provide the name of the policyholder and the policy number.

Neutral Evaluation

Neutral Evaluation may be appropriate for your case if the issues in dispute are clearly defined. *Neutral Evaluation* is an assessment of the issues in dispute by an experienced evaluator who will provide a non-binding opinion concerning the probable outcome if your case proceeds to court or arbitration. If your dispute has been referred to *Neutral Evaluation* by the mediator, please check off the appropriate box on the application.

Otherwise, if you wish to obtain *Neutral Evaluation* through the Commission, you must contact your insurance company. Both sides must agree to *Neutral Evaluation* and both sides must confirm that **all necessary documents and reports required for a determination of the issues have been obtained and exchanged.**

Arbitration Hearing

Please provide details concerning the arrangements you will require for an arbitration hearing. In most cases, both sides of a dispute want a hearing in person. However, in simple disputes where no witnesses will be called and little evidence will be filed, it is possible to speed up the arbitration process by holding a written or electronic hearing (e.g. by phone). In a written hearing, the arbitrator will decide the case based on the written materials submitted. *If you need an interpreter or other special services (such as sign language or wheelchair access), please give details in this section.*

Arbitration hearings are held at the Commission offices in North York for Applicants who live in the Greater Metropolitan Toronto Area. If you live outside the Greater Metropolitan Toronto Area, arrangements will be made to conduct a hearing in a location near your home.

Signature and Certification

Sign and date the form and return it along with two copies, to Arbitration Services of the Dispute Resolution Group at the Financial Services Commission of Ontario. Be sure to enclose a cheque or money order for **$100** payable to the **Minister of Finance**. *NOTE: Your application may be rejected if these steps have not been completed as requested.*

SECTIONS 2, 3, 4

You need to complete only ONE of these sections depending on the date of your motor vehicle accident. Discard unused sections.

***Section 2 – Complete if your motor vehicle accident occurred on or after* November 1, 1996.**

Section 3 – Complete if your motor vehicle accident occurred on or between* January 1, 1994 *and* October 31, 1996, *inclusive.

Section 4 – Complete if your motor vehicle accident occurred on or between* June 22, 1990 *and* December 31, 1993, *inclusive.

Issues in Dispute

Please check all of the benefits you want arbitrated under the appropriate section. Check the benefits that are still being disputed (as they appear on the Mediator's Report). *New issues cannot be added at this stage until they have been mediated.* Make sure you fill in the section that applies to the date of your accident.

SECTION 5 – Documents at the Hearing

You must complete Section 5. List key documents in your possession to which reference will be made in the arbitration. Also list key documents you intend to obtain from other sources, including those requested from the insurer, such as surveillance evidence.

Steps in the Arbitration Process

Step 1

Return the following items to Arbitration Services at the Commission. The full address is on the front of this form.

- Two copies of the completed Application for Arbitration, signed and dated (also keep one copy for yourself).
- Copy of the Mediator's Report (if available).
- Copy of Report of Neutral Evaluator, if neutral evaluation has taken place.
- Any information about your dispute that is relevant (i.e., doctor's reports, tax receipts or financial statements). **Send copies only – keep originals of all your documents.**
- **The $100 filing fee, payable to the Minister of Finance.**

Failure to comply with all these instructions may result in your application being returned to you.

Step 2

The Commission will send a copy of your completed Application to the insurance company. If you and the insurer jointly agree to refer your dispute to Neutral Evaluation at the Commission, a date will be set for the evaluation. If your case does not settle after the Neutral Evaluation, your case will move directly to Step 6 below.

Step 3

If your case is not referred to Neutral Evaluation, the insurance company must file a *Response by Insurer to an Application for Arbitration* with the Commission within 20 days of their receipt of your *Application for Arbitration*. The Response will state the company's position on the dispute and may raise further issues which were not resolved in mediation. You will get a copy of the Insurer's *Response by Insurer to an Application for Arbitration*.

Step 4 (optional)

You will have an opportunity to reply to what the insurance company has said. If you wish to reply, you can use the *Reply by the Applicant for Arbitration* form that is available from the Commission. You will have 10 days from the day you receive the insurance company's Response to reply. Send the insurance company and the Commission a copy of your reply.

Step 5

The Commission will set a date for a pre-hearing discussion with an arbitrator, before you have a hearing. You are required to produce and exchange all relevant documents and reports ***before*** the pre-hearing discussion. At the pre-hearing discussion, you and the insurance company will discuss the issues with an arbitrator and make arrangements for the hearing.

Step 6

If you have not settled the dispute after Neutral Evaluation or a pre-hearing discussion, a hearing will be scheduled. After the hearing, the written order of the arbitrator will be sent to you and the insurance company.

Note: You may settle your dispute with the insurance company directly at any time during the arbitration process.

Sample

Financial Services Commission of Ontario
Dispute Resolution Group

Application for Arbitration
Form C

Arbitration file number

Section 1 This section MUST be completed.

General Information

1. What was the date of the motor vehicle accident?
Month | Day | Year

2. Who is making this application?
☐ Applicant ☐ Applicant's representative

3. Have you applied for arbitration before?
☐ No ☐ Yes If Yes, please provide arbitration numbers ▶

4. Language preferred
☐ English ☐ French ☐ Other, specify ▶

5. Have you contacted the other party and tried to settle the dispute since mediation?
☐ No ☐ Yes

6. Provide mediation file number
M-

Have you attached a copy of the mediator's report?
☐ No ☐ Yes

Applicant

Last name | First name | Middle name
☐ Mr. ☐ Mrs. ☐ Ms.

Street address | City | Province | Postal Code

Home phone number ( ) | Work phone number ( ) | Fax number ( ) | Birthdate Month | Day | Year

1. What is the best way to reach you?
☐ phone ☐ mail ☐ fax ☐ through my representative

2. Where is the best place to reach you?
☐ home ☐ work ☐ other, specify ▶

3. When is the best time to reach you? Specify days of the week and time

4. Is the Applicant under a legal disability (a minor or mentally incapable)?
☐ No ☐ Yes If Yes, has a family member, or guardian, or court appointed guardian, been named? ☐ No ☐ Yes

Applicant's Representative

Last name | First name | File reference number
☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to the insured person
☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator/ trustee ☐ court appointed guardian ☐ other, specify ▶

Insurance Company

Company name

Claim representative name | Claim number

Policyholder name | Policy number

Form C
Application for Arbitration

Section 1 *continued*

Neutral Evaluation

1. Are any issues relating to this accident still in mediation?
   ☐ No ☐ Yes If Yes, provide mediation file number(s) ▶ M-
2. Does the mediator's report refer issues in dispute for neutral evaluation?
   ☐ No ☐ Yes
3. Have you referred any issues in dispute to a private sector neutral evaluator appointed by the Director of Arbitrations?
   ☐ No ☐ Yes
4. Did the neutral evaluator issue a written report?
   ☐ No ☐ Yes If Yes, attach a copy of the report
5. Do you want Neutral Evaluation through the Commission?
   ☐ No ☐ Yes If Yes, *do you certify that all documents or reports listed in the Report of Mediator have been exchanged and that no other documents are required for the purpose of evaluating the issues in dispute?*
   ☐ Yes ***Signature ▼***

Arbitration Hearing

1. Do you wish to have an oral arbitration hearing?
   ☐ No ☐ Yes
2. In simple disputes, it is possible to speed up the arbitration process by holding a written or electronic hearing. Do you wish to have a hearing based on written or electronic (by telephone) submissions only?
   ☐ No ☐ Yes
3. Do you wish the arbitration hearing to be conducted in French?
   ☐ No ☐ Yes
4. Will you require the services of an interpreter at the arbitration hearing?
   ☐ No ☐ Yes If Yes, what language? ▶
5. Do you require other special services such as wheelchair access or sign language interpreter?
   ☐ No ☐ Yes If Yes, please describe ▶
6. Do you require the hearing to be held outside the Greater Metropolitan Toronto Area?
   ☐ No ☐ Yes If Yes, where? ▶

Signature and Certification

I certify that all information in this Application and attachments is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to Arbitration Services at the Commission. I realize that copies of all information filed with this Application will be given to the other party in this dispute.

Applicant name (please print)

Applicant Signature
X

Representative name (please print)

Representative Signature
X

Date

☐ Cheque or money order enclosed

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Application.

I certify that my representative ▼

has full authorization as described above

Applicant Signature

Date

1850 (03/01)

ISSUES IN DISPUTE

The types of benefits available, the minimum and maximum amounts available and the rules to qualify for benefits may be different depending on when your motor vehicle accident took place. Fill in only that section covering the date of your accident.

You need to complete only ONE of sections 2, 3 or 4. (Discard unused sections.)

Section 2 – Complete if your motor vehicle accident occurred on or after November 1, 1996.

Section 3 – Complete if your motor vehicle accident occurred on or between January 1, 1994 and October 31, 1996, inclusive.

Section 4 – Complete if your motor vehicle accident occurred on or between June 22, 1990 and December 31, 1993, inclusive.

Section 2 Complete this section ONLY for motor vehicle accidents that occurred on or after November 1, 1996.

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Since you filed for mediation, has the insurer **asked you to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

No Yes If Yes, did you attend? ▶ No Yes If No, briefly explain ▼

Please note that in some cases, arbitration cannot take place until an Applicant has made him/herself reasonably available for an I.E.

2. Since you filed for mediation, has the insurer **asked you to attend an assessment at a D.A.C.** relating to any of the issues in dispute?

No Yes If Yes, did you attend? ▶ No Yes If No, briefly explain ▼

Please note that in some cases, arbitration cannot take place until an Applicant has made him/herself reasonably available for a D.A.C. assessment.

If Yes, to what benefit claim was the D.A.C. assessment related?

medical benefits

rehabilitation benefits

attendant care benefits

determination of catastrophic impairment

Name(s), address(es) and code(s) of the D.A.C.(s) if known *(Attach extra sheets, if necessary.)*

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

No Yes Partially

D.A.C. Code

2. Since you filed for mediation have you **asked to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

No Yes If Yes, to what benefits was the assessment related?

disability benefits (income replacement, non-earner or caregiver benefits)

disability benefits past 104 weeks of accident (income replacement or caregiver)

determination of catastrophic impairment

Name(s), address(es) and code(s) of the D.A.C.(s) if known *(Attach extra sheets, if necessary.)*

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

No Yes Partially

D.A.C. Code

Section 2 *continued*

Description of Dispute ***Check the benefits that were not resolved in mediation and which you now want evaluated or arbitrated. You cannot add new issues at this stage until they have been mediated.*** *(Add extra sheets, if necessary.)*

Do you have optional benefits?
☐ No ☐ Yes

For each benefit checked, briefly explain the details of the dispute. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼

☐ **Weekly Benefits**

Which weekly benefit are you disputing?
- ☐ income replacement
- ☐ non-earner

What are you disputing?
- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ benefits after age 65
- ☐ other, specify ▼

If you received income benefits, state weekly amount and duration of payments.
$
From To

Is the insurance company claiming a repayment of benefits?
☐ No ☐ Yes If Yes, amount ▼
$

☐ **Caregiver Benefits**

Amount in dispute?
$

What are you disputing?
- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ other, specify ▼

☐ **Medical Benefits**

Amount in dispute?
$

Does this claim involve catastrophic impairment?
☐ No ☐ Yes

☐ **Rehabilitation Benefits**

Amount in dispute?
$

☐ **Attendant Care Benefits**

Amount in dispute?
$

1850 (03/01)

Section 2 *continued*	For each benefit checked, briefly explain the details of the dispute. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼
☐ **Case Manager Services Benefits** — Amount in dispute? $	
☐ **Other Expenses** — Amount in dispute? $ What are you disputing? ☐ lost educational expenses ☐ expenses of visitors ☐ housekeeping and home maintenance ☐ damage to clothing, glasses, etc. ☐ cost of examinations	
☐ **Death Benefits** — Amount in dispute? $	
☐ **Funeral Expenses** — Amount in dispute? $	
☐ **Other Disputes** — Amount in dispute? $	
☐ **Interest** — Amount in dispute? Set out calculations. $	
☐ **Expenses of the Hearing**	
☐ **Special Award**	

After completing this Section, make sure that you have signed the Application at the end of Section 1, and that you have listed all of your documents in Section 5. Send two copies of Application Sections 1, 2 and 5, plus any extra sheets, to:

Arbitration Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Section 3 Complete this section ONLY for motor vehicle accidents that occurred on or between January 1, 1994 and October 31, 1996, inclusive.

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Since you filed for mediation, has the insurer **asked you to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did you attend? ☐ No ☐ Yes If No, briefly explain. ▼

Please note that in some cases, arbitration cannot take place until an Applicant has made him/herself reasonably available for an I.E.

2. Since you filed for mediation, has the insurer **asked you to attend an assessment at a D.A.C.** relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did you attend? ▶ ☐ No ☐ Yes If No, briefly explain. ▼

Please note that in some cases, arbitration cannot take place until an Applicant has made him/herself reasonably available for a D.A.C. assessment.

If Yes, to what benefit claim was the D.A.C. assessment related?

- ☐ supplementary medical benefits
- ☐ rehabilitation benefits
- ☐ attendant care benefits
- ☐ loss of earning capacity benefits

Name(s), address(es) and code(s) of the D.A.C.(s) if known *(Attach extra sheets, if necessary.)*

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

D.A.C. Code

3. Since you filed for mediation have you **asked to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

☐ No ☐ Yes If Yes, to what benefits was the assessment related?

- ☐ disability benefits (income replacement, education disability or caregiver benefits)
- ☐ loss of earning capacity benefits
- ☐ attendant care benefits

Name(s), address(es) and code(s) of the D.A.C.(s) if known *(Attach extra sheets, if necessary.)*

D.A.C. Code

Do you dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

D.A.C. Code

Sample

Section 3 *continued*

Description of Dispute ***Check the benefits that were not resolved in mediation and which you now want evaluated or arbitrated. You cannot add new issues at this stage until they have been mediated.*** *(Add extra sheets, if necessary.)*

For each benefit checked, briefly explain the details of the dispute. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼

☐ **Weekly Benefits**

Which weekly benefit are you disputing?

- ☐ income replacement
- ☐ education disability
- ☐ caregiver
- ☐ other disability

What are you disputing?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ benefits after age 65
- ☐ other, specify ▼

If you received income benefits, state weekly amount and duration of payments.

$

From To

Is the insurance company claiming a repayment of benefits?

☐ No ☐ Yes If Yes, amount ▼

$

Do you have a Pre-determined income from Self-Employment Agreement?

☐ No ☐ Yes

☐ **Loss of Earning Capacity Benefits**

Did you receive a Loss of Earning Capacity Benefits offer from the insurer?

☐ No If No ▼

☐ Claiming Loss of Earning Capacity Benefits

☐ Yes If Yes ▼

What part(s) of the offer are you disputing?

☐ Pre-accident earning capacity

☐ Residual Earning capacity

☐ **Education Disability Benefits (Lump Sum Benefits)**

Amount in dispute?

$

☐ **Medical Benefits**

Amount in dispute?

$

☐ **Rehabilitation Benefits**

Amount in dispute?

$

Section 3 *continued*

For each benefit checked, briefly explain the details of the dispute. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼

☐ **Attendant Care Benefits**
Amount in dispute?
$

☐ **Compensation for Other Pecuniary Losses**
Amount in dispute?
$
What are you disputing?
- ☐ expenses of visitors
- ☐ dependant care expenses
- ☐ housekeeping and home maintenance
- ☐ damage to clothing, glasses, etc.
- ☐ cost of examinations

☐ **Death Benefits**
Amount in dispute?
$

☐ **Funeral Expenses**
Amount in dispute?
$

☐ **Other Disputes**
Amount in dispute?
$

☐ **Interest**
Amount in dispute? Set out calculations
$

☐ **Expenses of the Hearing**

☐ **Special Award**

After completing this Section, make sure that you have signed the Application at the end of Section 1, and that you have listed all of your documents in Section 5. Send two copies of Application Sections 1, 3 and 5, plus any extra sheets, to:

Arbitration Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Section 4 — Complete this section ONLY for motor vehicle accidents that occurred on or between June 22, 1990 and December 31, 1993.

Insurer Examination (Medical) (I.E.) Information

Were you **asked by the insurance company to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did you attend? ▶ ☐ No ☐ Yes If No, briefly explain ▼

Please note that in some cases, arbitration cannot take place until an Applicant has made him/herself reasonably available for an I.E.

Description of Dispute

Check the benefits that were not resolved in mediation and which you now want evaluated or arbitrated. You cannot add new issues at this stage until they have been mediated. *(Add extra sheets, if necessary.)*

Do you have optional benefits?

☐ No ☐ Yes

For each benefit checked, briefly explain the details of the dispute. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼

☐ **Income Benefits**

Which income benefit are you disputing?

- ☐ employed benefits
- ☐ benefit if no income

What are you disputing?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 156 weeks
- ☐ other, specify ▼

If you received weekly income benefits, state amount per week and duration of payments.

$

From To

Is the insurance company claiming a repayment of benefits?

☐ No ☐ Yes If Yes amount ▼

$

☐ **Childcare Benefits**

What are you disputing?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ other, specify ▼

If you received weekly Childcare Benefits, state amount per week and duration of payments.

$

From To

Section 4 *continued*		For each benefit checked, briefly explain the details of the dispute. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼
☐ **Supplementary Medical/ Rehabilitation Benefits**	Amount in dispute? $	
☐ **Care Benefits**	Amount in dispute? $	
☐ **Death Benefits**	Amount in dispute? $	
☐ **Funeral Expenses**	Amount in dispute? $	
☐ **Other Disputes**	Amount in dispute? $	
☐ **Interest**	Amount in dispute? Set out calculations $	
☐ **Expenses of the Hearing**		
☐ **Special Award**		

After completing this Section, make sure that you have signed the Application at the end of Section 1, and that you have listed all of your documents in Section 5. Send two copies of Application Sections 1, 4 and 5, plus any extra sheets, to:

Arbitration Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Section 5 Document List This section MUST be completed.

It is expected that the Applicant and the Insurer have exchanged key documents prior to the filing of an Application for Arbitration.

(Attach extra sheets if necessary.)

Documents

1. Please explain why any document, identified in the **Report of Mediator** as having been requested by the insurer, has not been provided to the insurer prior to submitting your **Application for Arbitration**.

☐ Extra sheets attached

2. List key documents in your possession to which you will refer in the arbitration.
Identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

☐ Extra sheets attached

3. List key documents not currently in your possession, which you intend to get from other sources (such as employers, doctors, Revenue Canada) for use in your arbitration. You should also include any documents requested from the insurer (such as Insurer Examination (Medical) reports, surveillance evidence, a summary of benefits paid) which have not yet been provided.
Wherever possible, identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

☐ Extra sheets attached

After completing this Section, make sure that you have signed the Application at the end of Section 1. Send two copies of Application Sections 1, 5, and ONE of Sections 2, 3, or 4, depending on the accident date, plus any extra sheets, to:

Arbitration Services
Dispute Resolution Group
Financial Services Commission of Ontario

at the address shown on the front of this form.

Financial Services Commission of Ontario
Dispute Resolution Group

FORM D
AGREEMENT TO NEUTRAL EVALUATION AT THE COMMISSION (FAX-BACK FORM)

Personal information requested on this form is collected under the authority of the Insurance Act, R.S.O. 1990, c.I.8 as amended. This information, including documents submitted with this Form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, FSCO.

An ***Application for Arbitration*** has been filed with the Dispute Resolution Group of the Financial Services Commission of Ontario (the Commission). Your company is named as a party in this arbitration. Use this Form to consent to a request for neutral evaluation raised in the ***Application***.

This form may also be used by the insurer to request neutral evaluation through the Commission, where the applicant has NOT requested neutral evaluation in the ***Application***, provided the insurer obtains the Applicants written consent to neutral evaluation and no private neutral evaluation has been conducted in respect of the issues in dispute.

GENERAL INFORMATION

COMMISSION FILE NO. FOR ARBITRATION

Applicant/Insured Person

Last Name	First Name	Date of Accident: Month	Day	Year

Street Address	City	Province	Postal Code

Home Phone Number	Work Phone Number	Fax Number
( )	( )	( )

Insurance Company

Name		
Contact Person		
Street Address		
City	Province	Postal Code
Phone Number	Fax Number	Electronic Mail Address
Insurer Claim Number	Policyholder Name	Policy Number

(Rev. Mar/01)

Form D

Agreement to Neutral Evaluation at The Commission

1. Within **20 days** of the receipt by the insurer of the ***Application for Arbitration***, the insurer must respond in ONE of the following ways:

   (a) Where the insured person has requested neutral evaluation in the ***Application for Arbitration***, the insurer may consent to neutral evaluation by serving and filing this form on the applicant and the Office of the Registrar of the Dispute Resolution Group. The Commission requires service of this form upon the Commission by facsimile transmission.

   (b) Where the insured person has NOT requested neutral evaluation in the ***Application for Arbitration***, the insurer may request neutral evaluation by obtaining the written consent of the applicant and serving and filing the written consent and this form on the office of the Registrar. The Commission requires service of this form upon the Commission by facsimile transmission.

   (c) Upon receipt of the materials referred to in (a) or (b) above, the Director of Arbitrations will promptly appoint a person to perform the neutral evaluation and confirm the appointment with the parties. Where the insurer does not wish to refer the issues in dispute to neutral evaluation, the insurer must file a ***Response by Insurer to an Application for Arbitration*** in **Form E,** pursuant to Rule 27 of the Dispute Resolution Practice Code.

2. The applicant requested neutral evaluation through the Commission in the ***Application for Arbitration***:

   Yes ☐ No ☐

   (a) If **YES**, the insurer hereby **CONSENTS** to a referral of the issues in dispute in this arbitration, to a person appointed by the Director of Arbitrations, for a neutral evaluation of the probable outcome of a proceeding in arbitration.

   (b) If **NO**, the insurer hereby **REQUESTS** a referral of the issues in dispute in this arbitration to a person appointed by the Director of Arbitrations for a neutral evaluation. The insurer has attached a copy of the written consent of the applicant to a referral of the issues in dispute in the arbitration to neutral evaluation at the Commission.

   Yes ☐

3. The insurer hereby certifies that all documents required for an evaluation of the issues in dispute in this arbitration have been exchanged by the parties or will be exchanged **within 30 days** of the date of this Form, and that no other documents or reports are required for the neutral evaluation.

4. The person identified below will be available for a neutral evaluation **within 60 days** from the date of this Form. The insurer confirms that the following two half-day dates are available to both parties:

   _____ a.m.__ p.m.__

   _____ a.m.__ p.m.__

(Rev.Mar/01)

Form D

Agreement to Neutral Evaluation at The Commission

THE PERSON HANDLING THIS FILE, WITH BINDING AUTHORITY, ON BEHALF OF THE INSURANCE COMPANY:

Name of Company Representative		
Last Name	First Name	Title
Phone Number	Fax Number	Electronic Mail Address
ADR Coordinator's Signature		Date

Or the Insurance Company's legal representative		
Name	Law Firm	File Reference Number
Street Address		
City	Province	Postal Code
Phone Number	Fax Number	Electronic Mail Address

Sample

(Rev. Mar/01)

Ontario

Financial Services Commission of Ontario

Dispute Resolution Group

Response by Insurer to an Application for Arbitration

Form E

Arbitration file number

An **Application for Arbitration** has been filed with the Dispute Resolution Group of the Financial Services Commission of Ontario (the "Commission"). A copy of the **Application for Arbitration** is attached. Your company is named as a party in this arbitration. Use this form to respond to the issues raised in the Application. You can add new issues which have been mediated but not settled. You must serve a copy of this **Response** on the Applicant and provide proof of service to the Commission. This must be done within **20 days** of receiving this document. This **Response** need not be completed if the Insurer agrees to the applicant's request for Neutral Evaluation, or the Applicant consents to an **Agreement to Neutral Evaluation at the Commission** within **20 days** of receiving this document.

If the Applicant has not requested Neutral Evaluation through the Commission but the Insurer wishes to request Neutral Evaluation, the Insurer must contact the Applicant and his/her representative (if any), to obtain the Applicant's written consent to Neutral Evaluation. This written consent and an **Agreement to Neutral Evaluation at the Commission (Form D)** must be filed within **20 days** of receipt by the Insurer of the **Application for Arbitration**.

The Insurer must complete and sign Section 1.

The Insurer must complete ONE of Sections 2, 3, or 4, depending on the accident date, plus any required extra sheets.

The Insurer must complete Section 5. List key documents in the insurer's possession to which reference will be made in the arbitration, such as surveillance evidence. Also list key documents the Insurer intends to obtain from other sources, including those requested from the Applicant, such as financial or employment records.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c. I.8, as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Financial Services Commission of Ontario.

Section 1 This section MUST be completed.

Applicant

Date of the motor vehicle accident?
Month | Day | Year

Last name | First name | Middle name

Mr. Mrs. Ms.

Insurance Company

Company name

Contact person – Last name | First name

Mr. Mrs. Ms.

Street address | City | Province | Postal Code

Phone number | Fax number | Electronic mail address

( ) | ( )

Insurer's claim number | Policyholder name | Policy number

Legal Representative

Last name | First name | File reference number

Mr. Mrs. Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number | Fax number | Electronic mail address

( ) | ( )

 Ce formulaire est également disponible en français.

1851 (03/01)

Form E

Response by Insurer to an Application for Arbitration

Section 1 *continued*

Neutral Evaluation

1. Are any issues relating to this accident still in mediation?

No Yes If Yes, provide mediation file number(s) ▶ M-

2. Does the mediator's report refer issues in dispute for neutral evaluation?

No Yes

3. Have you referred any issues in dispute to a private sector neutral evaluator appointed by the Director of Arbitrations?

No Yes

4. Did the neutral evaluator issue a written report?

No Yes If Yes, attach a copy of the report

5. Do you want Neutral Evaluation through the Commission?

No Yes If Yes, *do you certify that all documents or reports listed in the Report of Mediator have been exchanged and that no other documents are required for the purpose of evaluating the issues in dispute?*

Yes ***Signature*** ▼

Type of Hearing

1. Does the insurer wish to have an oral hearing?

No Yes

2. In simple disputes, it is possible to speed up the arbitration process by holding a written or electronic hearing where the arbitrator will decide the case based on the written material submitted. Does the insurer wish to have a hearing based on electronic (by telephone) or written submissions only?

No Yes

3. Does the insurer require special service such as audio visual equipment?

No Yes If Yes, please describe ▶

4. Will the insurer be arranging for the services of a Court Reporter?

No Yes

Signature and Certification

I certify that all information in this Response and attachments is true and complete. I realize that copies of all information filed with this Response will be given to the other party in this dispute.

Name Title Signature

Date

1851 (03/01)

Form E

Response by Insurer to an Application for Arbitration

ISSUES IN DISPUTE

The types of benefits available, the minimum and maximum amounts available and the rules to qualify for benefits may be different depending on when your motor vehicle accident took place. Fill in only that section covering the date of your accident.

You need to complete only ONE of sections 2, 3 or 4. (Discard unused sections.)

Section 2 – Complete if your motor vehicle accident occurred on or after November 1, 1996.

Section 3 – Complete if your motor vehicle accident occurred on or between January 1, 1994 and October 31, 1996, inclusive.

Section 4 – Complete if your motor vehicle accident occurred on or between June 22, 1990 and December 31, 1993, inclusive.

Section 2 Complete this section ONLY for motor vehicle accidents that occurred on or after November 1, 1996.

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Since the conclusion of mediation did the **insurance company ask the Applicant to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

No Yes If Yes, did the Applicant attend? ▶ No Yes If No, state reason(s) ▼

2. Since the conclusion of mediation did the **insurance company ask the Applicant to attend an assessment at a D.A.C.** relating to any of the issues in dispute?

No Yes If Yes, did the Applicant attend? ▶ No Yes If No, state reason(s) ▼

If Yes, to what benefit claim was the D.A.C. assessment related?

- medical benefits
- rehabilitation benefits
- attendant care benefits
- determination of catastrophic impairment

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Does the insurer dispute the outcome of the D.A.C.?

No Yes Partially

3. Since the conclusion of mediation did the **Applicant ask to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

No Yes If Yes, to what benefits was the assessment related?

- disability benefits (income replacement, non-earner or caregiver benefits)
- disability benefits past 104 weeks of accident (income replacement or caregiver)
- determination of catastrophic impairment

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Does the insurer dispute the outcome of the D.A.C.?

No Yes Partially

Form E

Response by Insurer to an Application for Arbitration

Section 2 *continued*

Description of Dispute

Check the benefits that were not resolved in mediation and which the insurer now wants to respond to or now wants evaluated or arbitrated. The insurer may add new issues which have been mediated but not settled. *(Add extra sheets, if necessary.)*

Does the Applicant have optional benefits?

☐ No ☐ Yes

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach extra sheets if necessary.)* ▼

☐ **Weekly Benefits**

Which weekly benefits are being disputed?

- ☐ income replacement
- ☐ non-earner

What is being disputed?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ benefits after age 65
- ☐ other, specify ▼

If the insurer paid weekly benefits, state weekly amount and duration of payments.

$

From To

Is the insurance company claiming a repayment of benefits?

☐ No ☐ Yes If Yes amount ▼

$

☐ **Caregiver Benefits**

Amount in dispute?

$

What is being disputed?

- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ entitlement to benefits past 104 weeks
- ☐ other, specify ▼

☐ **Medical Benefits**

Amount in dispute?

$

Does this claim involve catastrophic impairment?

☐ No ☐ Yes

☐ **Rehabilitation Benefits**

Amount in dispute?

$

☐ **Attendant Care Benefits**

Amount in dispute?

$

Form E

Response by Insurer to an Application for Arbitration

Section 2 *continued*

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach extra sheets if necessary.)* ▼

☐ **Case Manager Services Benefits**	Amount in dispute? $	
☐ **Other Expenses**	Amount in dispute? $ What is being disputed? ☐ lost educational expenses ☐ expenses of visitors ☐ housekeeping and home maintenance ☐ damage to clothing, glasses, etc. ☐ cost of examinations	
☐ **Death Benefits**	Amount in dispute? $	
☐ **Funeral Expenses**	Amount in dispute? $	
☐ **Other Disputes**	Amount in dispute? $	
☐ **Claim for Repayment**	Amount in dispute? $	
☐ **Interest**	Amount in dispute? Set out calculations. $	
☐ **Expenses of the Hearing**		
☐ **Abuse of process, Frivolous or Vexatious Proceedings**		
☐ **Response to Special Award Claim**		

1881 (03/01)

Sample

Section 3 Complete this section ONLY for motor vehicle accidents that occurred on or between January 1, 1994 and October 31, 1996, inclusive.

Insurer Examination (Medical) (I.E.) and Designated Assessment Centre (D.A.C.) Information

1. Since the conclusion of mediation did the **insurance company ask the Applicant to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Applicant attend? ▶ ☐ No ☐ Yes If No, state reason(s). ▼

2. Since the conclusion of mediation did the **insurance company ask the Applicant to attend an assessment at a D.A.C.** relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Applicant attend? ▶ ☐ No ☐ Yes If No, state reason(s). ▼

If Yes, to what benefit claim was the D.A.C. assessment related?

☐ medical benefits
☐ rehabilitation benefits
☐ attendant care benefits
☐ loss of earning capacity benefits

Does the insurer dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

3. Since the conclusion of mediation did the **Applicant ask to attend an assessment at a D.A.C.** relating to any of the benefits in dispute?

☐ No ☐ Yes If Yes, to what benefits was the assessment related?

☐ disability benefits (income replacement, education disability or caregivers benefits)
☐ loss of earning capacity benefits

Does the insurer dispute the outcome of the D.A.C.?

☐ No ☐ Yes ☐ Partially

Name(s), address(es) and code(s) of the D.A.C.(s) *(Attach extra sheets, if necessary.)*

D.A.C. Code

D.A.C. Code

Section 3 *continued*

Description of Dispute

Check the benefits that were not resolved in mediation and which the insurer now wants to respond to or now wants evaluated or arbitrated. The insurer may add new issues which have been mediated but not settled.
(Add extra sheets, if necessary.)

		For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach extra sheets if necessary.)* ▼
☐ **Weekly Benefits**	Which weekly benefit is being disputed? ☐ income replacement ☐ education disability ☐ caregiver ☐ other disability What is being disputed? ☐ initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefits ☐ entitlement to benefits past 104 weeks ☐ benefits after age 65 ☐ other, specify ▼ If the insurer paid weekly benefits, state weekly amount and duration of payments. $ From To Is the insurance company claiming a repayment of benefits? ☐ No ☐ Yes If Yes amount ▼ $ Does the Applicant have a Pre-determined income from Self-Employment Agreement? ☐ No ☐ Yes	
☐ **Loss of Earning Capacity Benefits**	Did the insurer offer a Loss of Earning Capacity Benefit to the Applicant? ☐ No If No ▼ ☐ Disputing Loss of Earning Capacity Benefits ☐ Yes If Yes ▼ What part(s) of the offer are being disputed? ☐ Pre-accident earning capacity ☐ Residual Earning capacity	
☐ **Education Disability Benefits (Lump Sum Benefits)**	Amount in dispute? $	
☐ **Medical Benefits**	Amount in dispute? $	
☐ **Rehabilitation Benefits**	Amount in dispute? $	

Sample

Form E

Response by Insurer to an Application for Arbitration

Section 3 *continued*

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach extra sheets if necessary.)* ▼

☐ **Attendant Care Benefits**	Amount in dispute? $	
☐ **Compensation for Other Pecuniary Losses**	Amount in dispute? $ What is being disputed? ☐ expenses of visitors ☐ dependent's care expenses ☐ housekeeping and home maintenance ☐ damage to clothing, glasses, etc. ☐ cost of examinations	
☐ **Death Benefits**	Amount in dispute? $	
☐ **Funeral Expenses**	Amount in dispute? $	
☐ **Other Disputes**	Amount in dispute? $	
☐ **Claim for Repayment**	Amount in dispute? $	
☐ **Interest**	Amount in dispute? Set out calculations. $	
☐ **Expenses of the Hearing**		
☐ **Abuse of process, Frivolous or Vexatious Proceedings**		
☐ **Response to Special Award Claim**		

Form E

Response by Insurer to an Application for Arbitration

Section 4 Complete this section ONLY for motor vehicle accidents that occurred on or between June 22, 1990 and December 31, 1993.

Insurer Examination (Medical) (I.E.) Information

Since the conclusion of the mediation did the **insurance company ask the Applicant to attend an Insurer Examination (Medical)** (I.E.) relating to any of the issues in dispute?

☐ No ☐ Yes If Yes, did the Applicant attend? ▶ ☐ No ☐ Yes If No, state reason(s). ▼

Description of Dispute

Check the benefits that were not resolved in mediation and which the insurer now wants to respond to or now wants evaluated or arbitrated. The insurer may add new issues which have been mediated out not settled. *(Add extra sheets, if necessary.)*

Does the Applicant have optional benefits?
☐ No ☐ Yes

For each benefit checked, briefly explain the insurer's position on the issues in dispute. *(Attach extra sheets if necessary.)* ▼

☐ **Income Benefits**

Which income benefit is being disputed?
- ☐ employed benefits
- ☐ benefit if no income

What is being disputed?
- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of weekly benefits
- ☐ entitlement to benefits past 156 weeks
- ☐ other, specify ▼

If the insurer paid weekly income benefits, state amount per week and duration of payments.

$
From To

Is the insurance company claiming a repayment of benefits?
☐ No ☐ Yes If Yes, amount ▼

$

☐ **Childcare Benefits**

What is being disputed?
- ☐ initial entitlement to benefits
- ☐ length of time benefits were paid
- ☐ amount of benefits
- ☐ other, specify ▼

If the insurer paid weekly income Childcare Benefits to the Applicant, state amount per week and duration of payments.

$
From To

Section 4 *continued*

		For each benefit checked, briefly explain why you want arbitration. Refer to disputed issues in mediation report. *(Attach extra sheets if necessary.)* ▼
☐ **Supplementary Medical/ Rehabilitation Benefits**	Amount in dispute? $	
☐ **Care Benefits**	Amount in dispute? $	
☐ **Death Benefits**	Amount in dispute? $	
☐ **Funeral Expenses**	Amount in dispute? $	
☐ **Other Disputes**	Amount in dispute? $	
☐ **Claim for Repayment**	Amount in dispute? $	
☐ **Interest**	Amount in dispute? Set out calculations. $	
☐ **Expenses of the Hearing**		
☐ **Abuse of process, Frivolous or Vexatious Proceedings**		
☐ **Response to Special Award Claim**		

Section 5 Document List This section MUST be completed.

It is expected that the Applicant and the Insurer have exchanged key documents prior to the filing of a Response by Insurer to an Application for Arbitration.

(Attach extra sheets if necessary.)

Documents

1. Please explain why any document, identified in the **Report of Mediator** as having been requested by the Applicant, has not been provided to the Applicant prior to submitting your **Response by Insurer to an Application for Arbitration**.

☐ Extra sheets attached

2. List key documents in the insurer's possession to which you will refer in the arbitration.
Identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.

☐ Extra sheets attached

3. List key documents not currently in the insurer's possession, which you intend to get from other sources (such as employment records, Ontario Health Insurance records, Revenue Canada records) for use in the arbitration. The insurer should also include any documents requested from the Applicant (such as financial or employment records) which have not yet been provided. *Wherever possible, identify the type of document (letter, medical report, tax return), the name of the writer or issuing institution and the date of the document.*

☐ Extra sheets attached

After completing this Section, make sure that you have signed the Response at the end of Section 1.
Compile one copy of the Response, Sections 1, 5, and ONE of Sections 2, 3, or 4, depending on the accident date, plus any extra sheets.

Keep one set of these documents.

Send one set of these documents to the Applicant at the address noted in the Application for Arbitration.

Send one set of these documents to the Commission at:

Arbitration Services
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 14th Floor, Box 85
North York ON M2N 6L9

Enquiries:
In Toronto: (416) 250-6714, extension 7202
Toll Free: 1-800-517-2332, extension 7202
Fax: (416) 590-8462
Arbitration Hotline: (416) 590-7202

Ontario

Financial Services Commission of Ontario

Dispute Resolution Group

Statement of Service
Form F

This is a three part form.
White - Financial Services Commission of Ontario
Canary - Insurance Company
Pink - Insured Person

The purpose of this statement is to verify that a copy of a document was delivered to a party. A *Statement of Service* must be completed for every document served and given to the insured person and the insurance company, or their representatives. **Do not use this form where proof of service of a *Summons to Witness* and payment is required to be filed with the Commission.** In this case, you should use an ***Affidavit of Service for Summons to Witness*** which is available at the Commission.

Case Information

Insured Person | Insurance Company | Commission file number

Who are you?

Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Occupation

Street address | City | Province | Postal Code

Who was served?

Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Street address | City | Province | Postal Code

What was served?

Arbitration Documents
- ☐ Response by Insurer to an Application for Arbitration
- ☐ Reply by the Applicant for Arbitration
- ☐ Other (please specify below)

Appeal Documents
- ☐ Notice of Appeal
- ☐ Response to Appeal
- ☐ Application for Variation/Revocation
- ☐ Response to Application for Variation/Revocation
- ☐ Application for Intervention
- ☐ Other (please specify ▼)

How was it served?
- ☐ Personal Delivery
- ☐ Courier (give name of company ▼)
- ☐ Fax
- ☐ Regular mail
- ☐ Registered mail
- ☐ Other (please specify ▼)

Name of Service User

Address Served To: Street address | City | Province | Postal Code

Date of Service | Time of Service

A copy of the fax transmission record, or the courier or postal receipt may be required as evidence to support this Statement.

Your Signature

Signature of Person Who Served | Date

Ce formulaire est également disponible en français.

1855 (03/01)

Financial Services Commission of Ontario
Dispute Resolution Group
Ontario

Reply by the Applicant for Arbitration

Form G

Arbitration file number

Use this form to reply to any **point** made by the insurance company in its *Response* to your *Application for Arbitration*. You **must** reply to any **new** issues raised by the insurance company in their *Response*. If no new issues are raised by the insurance company, this *Reply* is optional. You must serve a copy of the *Reply* on the Insurance Company **within 10 days of your receipt of the** *Response by the Insurer* to your Application. You must also file the *Reply* and a *Statement of Service* with the Commission.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c. I.8, as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Financial Services Commission of Ontario.

Applicant

Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Legal Representative

If your representative has changed since you applied for Arbitration, give details of your new representative.

Last name | First name | File reference number

☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Insurance Company

Company name

Reply

Please reply to the insurance company's position on the issues in dispute. *Attach extra sheets if necessary.*

☐ Additional sheets attached

Signature

I certify that all information in this Reply and attachments is true and complete. I realize that copies of all information filed with this Reply will be given to the other party in this dispute.

Name | Signature | Date

☐ Applicant
☐ Representative

Ce formulaire est également disponible en français.

1975 (03/01)

Financial Services Commission of Ontario
Dispute Resolution Group

Ontario

FORM H
JOINT STATEMENT FOR NEUTRAL EVALUATION AT THE COMMISSION (FAX-BACK FORM)

THIS FORM MUST BE COMPLETED BY BOTH PARTIES AND RETURNED TO THE DISPUTE RESOLUTION GROUP, ARBITRATION UNIT, OF THE FINANCIAL SERVICES COMMISSION OF ONTARIO (THE COMMISSION) **WITHIN 30 DAYS** OF THE DATE OF THE **NOTICE OF APPOINTMENT OF A NEUTRAL EVALUATOR** RECEIVED FROM THE DIRECTOR.

TO: _____ **Arbitration Fax: (416) 590-8462**
(Name of the Commission Case Administrator)

RE: NAME OF CASE _____

COMMISSION FILE No. - A _____

We hereby certify that all documents listed in the **Report of Mediator** and all other documents necessary for an evaluation of the issues in dispute have been exchanged by the parties.

Listed below are the issues remaining in dispute that are to be submitted to the neutral evaluator.
(Add more pages if required)

1. _____

2. _____

3. _____

The parties agree they are available on the following dates (**within 60 days** of the date of the **Notice of Appointment of a Neutral Evaluator**) for a half day evaluation:

Date:

1 _____ a.m.__ p.m.__

2. _____ a.m.__ p.m.__

SIGNATURES:	
Applicant or Applicant's Representative	Insurer or Insurer's Representative
Date	Date

(Rev. Mar/01)

Financial Services Commission of Ontario

Dispute Resolution Group

Notice of Appeal
Form I

Use this form to appeal an Arbitration decision. **Appeals are only allowed on questions of law.**

You must file your completed *Notice of Appeal* with the Financial Services Commission of Ontario (the "Commission") at the address below, **within 30 days** of the date of the arbitration order you wish to appeal. The Director of Arbitrations may extend the time based on the reasons for the delay and the apparent strength of the appeal. The steps you must take are set out in this form.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

If you have any questions or want more information, contact:

Appeals Unit
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor, Box 85
North York ON M2N 6L9

In Toronto: (416) 590-7222

Toll Free: 1-800-517-2332, extension 7222

Fax: (416) 590-7077

Commission website: www.fsco.gov.on.ca

Sample

Ce formulaire est également disponible en français.

1976 (03/01)

Appealing an Arbitration Decision

For a complete set of the rules for appeals, see the *Dispute Resolution Practice Code*.

Step 1

Complete this *Notice of Appeal* form within **30 days** of the date of the Arbitration order. If the *Notice of Appeal* is incomplete, it may be rejected. After completing the form, you must serve a copy on the respondent (the other party). If the respondent was represented at the arbitration hearing by a lawyer, you should serve the *Notice of Appeal* on the lawyer. If not, serve the respondent.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the *Dispute Resolution Practice Code*.

Then file the following with the Commission:

- Completed *Notice of Appeal*
- Original *Statement of Service* form stating when and how you served the respondent with the *Notice of Appeal*
- The fee

Step 2

Upon receiving a properly completed *Notice of Appeal*, *Statement of Service* and the application fee, the Commission will promptly acknowledge the appeal.

Step 3

To oppose your appeal, the respondent must file a *Response to Appeal* within **20 days** of receiving acknowledgement of the appeal from the Commission. You will get a copy of the *Response to Appeal* from the respondent.

Step 4

Unless the Director of Arbitrations or an adjudicator delegated by the Director (known as Director's Delegate) advises you differently, your written submissions must be served on the respondent and filed with the Commission within **30 days** of the date the *Response to Appeal* was due. If a transcript is ordered, this time limit is extended to **30 days** from receipt of the transcript.

Step 5

The Director or Director's Delegate may decide the appeal with or without a hearing.

How to Complete the Notice of Appeal

PLEASE PRINT

Arbitration Decision Details

This information can be found in the arbitration decision.

Appellant's Name and Address

Fill in completely. Provide any alternative addresses, phone numbers, fax numbers or electronic mail addresses that will make it easier for us to contact you.

Appellant's Representative

You may choose to have someone represent you. Although many people are represented by a lawyer in an appeal, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the appeal. A minor (a person under the age of 18) or a person who has been declared mentally incapable, must have a representative.**

Reasons for the Appeal

Appeals are only available on questions of law. If your appeal does not involve a question of law, it may be rejected.

Briefly state what part(s) of the Arbitration order you are appealing and the error(s) of law you claim the arbitrator made. Attach extra sheets if necessary. Your *Notice of Appeal* must be sufficiently detailed to allow the other party to respond. It is not necessary, however, for you to file your complete written submissions until later.

Action Sought

Briefly state the remedy or outcome you are seeking in your appeal.

Transcript

Indicate if the Arbitration hearing was recorded by a reporting service. If it was recorded, indicate if you have ordered a transcript of the hearing. If you do not intend to order a transcript, you must state why a transcript is not needed for the appeal.

Stay

The usual rule is that an appeal does not stop the Arbitration order from taking effect. If you are asking that the Arbitration order not go into effect, you must explain why the usual rule should not apply.

It is likely that the stay will be decided without further submissions, so your reasons should be as complete as possible.

Appeal from a Preliminary or Interim Order

The usual rule is that a party may not appeal a preliminary or interim order of an arbitrator until all of the issues in the arbitration dispute have been finally decided. If you are seeking to appeal a preliminary or interim order, you must explain why the usual rule should not apply.

It is likely that this issue will be decided without further submissions so your reasons should be as complete as possible.

Evidence

Appeals are usually decided based on the evidence presented at the arbitration hearing. The Director's Delegate will have access to the arbitration exhibits and, therefore, it is not necessary to refile them.

If you want to rely on any additional or new evidence – documents or witnesses – you must explain what the evidence is and why it should be allowed in the appeal.

This issue may be decided without further submissions so your explanation should be as detailed as possible.

Signature

Sign the form and return it to the Appeals Unit at the Commission.

Fee

If you are an insured person, be sure to enclose the filing fee of $250 by cheque or money order made out to the **MINISTER OF FINANCE. The application will be rejected if the filing fee is not enclosed.**

If you are an insurer, the Commission will invoice your company for the filing fee (**$250**) and the insurer assessment (**$500**).

Note: You may settle your dispute with the respondent directly at any time during the appeal process.

1976 (03/01)

Financial Services Commission of Ontario
Dispute Resolution Group

Notice of Appeal

Complete ALL sections.
Attach extra sheets if necessary.

Commission file number
P-

Arbitration Decision Details

Applicant | Insurer(s)

Date of Arbitration decision | Arbitrator | Arbitration file number

Appellant

Company name **OR** Last name | First name | Middle name

☐ Mr.
☐ Mrs.
☐ Ms.

Street address | City | Province | Postal Code

Home phone number ( ) | Work phone number ( ) | Fax number ( ) | Electronic mail address

Appellant's Representative

Last name | First name | File reference number

☐ Mr.
☐ Mrs.
☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to the Appellant

☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator/ trustee ☐ court appointed guardian ☐ other, specify ▶

Reasons for the Appeal

Briefly explain the reasons for your appeal (questions of law only).

☐ Extra sheets attached

Actions Sought from the Appeal

Briefly explain what outcome or result you are looking for in the Appeal.

☐ Extra sheets attached

1976 (03/01)

Form I
Notice of Appeal

Transcripts

Was the Arbitration recorded? ☐ No ☐ Yes

Are you ordering a transcript of the hearing? ☐ No ☐ Yes

If Yes, you must inform the other party and arrange for a transcript copy to be provided to him/her and the Director's Delegate. State when you expect to receive the transcript. ▼

If No, briefly explain why a transcript is not needed for the Appeal. ▼

☐ Extra sheets attached

Stay of the Arbitration Order

Are you asking for a Stay of the Arbitration Order?

☐ No ☐ Yes If Yes, briefly explain why you are asking for a Stay. Your reasons should be as complete as possible ▼

☐ Extra sheets attached

Appeal from a Preliminary or Interim Order

Are you asking for an Appeal of a Preliminary or Interim Order?

☐ No ☐ Yes If Yes, briefly explain why you should be permitted to appeal a preliminary or interim order. Your reasons should be as complete as possible ▼

☐ Extra sheets attached

Evidence

List any evidence that you intend to rely on that was not part of the Arbitration hearing. Explain why this evidence is necessary. Your explanation should be as complete as possible.

☐ Extra sheets attached

Signature and Certification

I certify that all information in this Notice of Appeal and attachments is true and complete. I realize that copies of all information filed with this Notice of Appeal will be given to the other party in this dispute.

Name (please print)

Title

☐ Appellant
☐ Representative

Signature

Date

☐ Cheque or money order enclosed

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Appeal.

I certify that my representative *(name of representative ▼)*

has full authorization as described above

Appellant Signature

Date

Total number of extra sheets attached

1976 (03/01)

Financial Services Commission of Ontario
Dispute Resolution Group

Response to Appeal
Form J

Use this form if you want to oppose a *Notice of Appeal* filed by another party to the arbitration hearing.

You must file this *Response to Appeal* with the Commission (address below) within **20 days** of receiving a letter from the Commission acknowledging the appeal. The Director of Arbitrations may extend the time limit based on the reasons for the delay and the apparent strength of the appeal. The steps you must take are set out in this form.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

If you have any questions about this application, or want more information, contact:

Appeals Unit
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor, Box 85
North York ON M2N 6L9

In Toronto: (416) 590-7222

Toll Free: 1-800-517-2332, extension 7222

Fax: (416) 590-7077

Commission website: www.fsco.gov.on.ca

Ce formulaire est également disponible en français.

1848 (03/01)

For a complete set of rules for appeals, see the *Dispute Resolution Practice Code.*

Responding to an Appeal

Upon receiving a properly completed *Notice of Appeal*, the Commission will promptly acknowledge the appeal by sending letters to all parties to the arbitration hearing.

If you want to oppose the *Notice of Appeal*, you must respond within **20 days** of receiving a letter from the Commission acknowledging the appeal. The Director of Arbitrations can extend the time limit based on the reasons for the delay and the apparent strength of the appeal.

Step 1

Complete this *Response to Appeal* form. After completing the form, you must serve a copy on the appellant. If the *Notice of Appeal* shows that the appellant is represented, you must serve the representative. If not, serve the appellant.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the *Dispute Resolution Practice Code*.

Then file the following with the Commission:

- Completed *Response to Appeal*
- Original *Statement of Service* form stating when and how you served the appellant with the *Response to Appeal*

Fee

If you are an insured person, there is no fee for filing a *Response to Appeal*.

If you are an insurer, the Commission will invoice your company the insurer assessment **($500)**.

Cross-appeals

If, in addition to responding to the *Notice of Appeal*, you also want to appeal any part of the arbitration order, you must file your own *Notice of Appeal*. The rules for appeals apply to "cross appeals" including time limits and filing fee **($250)** and insurer assessment.

Step 2

When you receive the appellant's written submissions, your written submissions must then be served on the appellant and filed with the Commission within **20 days**.

Step 3

The Director or Adjudicator delegated or appointed by the Director of Arbitrations (known as the Director's Delegate, may decide the appeal with or without a hearing.

How to Complete the *Response to Appeal*

Please print.

Appellant

This information can be found in the *Notice of Appeal*.

Respondent's Name and Address

Fill in completely. Provide any alternative addresses, phone numbers or fax numbers that will make it easier for us to contact you.

Respondent's Representative

You may choose to have someone represent you. Although many people are represented by a lawyer in an appeal, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please state the name of the firm. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the appeal. A minor (a person under the age of 18) or a person who has been declared mentally incapable, must have a representative.**

Response to Appeal

Briefly state your response to the reasons for appeal set out in the *Notice of Appeal*. Attach extra sheets if necessary. Although you should state your position, it is not necessary for you to file your complete written submissions until later.

Response to Preliminary Matters

Provide your response to the preliminary matters raised in the *Notice of Appeal* (transcript, stay, preliminary or interim order, new evidence). The Director of Arbitrations or Director's Delegate may decide the preliminary matters without further submissions, so your response should be set out in detail. Attach extra sheets if necessary.

Transcript

If the appellant does not intend to order a transcript, you may state whether you think a transcript is needed for the appeal.

Stay of the Arbitration Order

The usual rule is that an appeal does not stop the arbitration order from taking effect. If you are asking that the arbitration order not go into effect, you must explain why the usual rule should not apply.

It is likely that the stay will be decided without further submissions, so your reasons should be as complete as possible.

Appeal from a Preliminary or Interim Order

The usual rule is that a party may not appeal a preliminary or interim order of an arbitrator until all of the issues in dispute in the arbitration have been finally decided. If you object to the appeal of the preliminary or interim order, you must explain your objection.

It is likely that the issue of the right to appeal from a preliminary or interim order will be decided without further submissions, so your reasons should be as complete as possible.

Evidence

Appeals are usually decided based on the evidence presented at the arbitration hearing. The Director's Delegate will have access to the arbitration exhibits and therefore, it is not necessary to refile them.

If you want to rely on any additional or new evidence – documents or witnesses – you must explain what the evidence is and why it should be allowed in the appeal.

If you object to the introduction of new evidence, you should explain why you object.

This issue may be decided without further submissions, so your explanation should be as detailed as possible.

Signature

Sign the form and return it to the Appeals Unit at the Commission.

Note: You may settle your dispute with the appellant directly at any time during the arbitration process.

Ontario

Financial Services Commission of Ontario

Dispute Resolution Group

Response to Appeal

Form J

Complete ALL sections.
Attach extra sheets if necessary.

Appeal file number
P-

Appellant

Company name **OR** Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Respondent's name and address

Company name **OR** Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Street address | City | Province | Postal Code

Phone number ( ) | Fax number ( ) | Electronic mail address

Respondent's Representative

Last name | First name | File reference number

☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to the Respondent

☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator/ trustee ☐ court appointed guardian ☐ other, specify ▶

Response to Appeal

Briefly explain your response to the appellant's reasons for appeal. (Questions of law only.)

☐ Extra sheets attached.

1848 (03/01)

Form J

Response to Appeal

Response to Preliminary Matters

Set out your response to the preliminary matters raised in the **Notice of Appeal** (transcript, stay, appeal of a preliminary or interim order, new evidence). *See instruction sheet for details.* **Your response should be as complete as possible.**

Extra sheets attached

Signature and Certification

I certify that all information in this Response to Appeal and attachments is true and complete. I realize that copies of all information filed with this Response to Appeal will be given to the other party in this dispute.

Name (please print) | Title | Respondent / Representative

Signature | Date

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Appeal.

I certify that my representative *(name of representative ▼)*

has full authorization as described above

Respondent Signature | Date | **Total number of extra sheets attached**

Financial Services Commission of Ontario

Dispute Resolution Group

Application for Intervention

Form K

Commission file number

Complete ALL sections.
Attach extra sheets if necessary.

Use this *Application* to intervene in an appeal before the Commission. You must serve a copy of this *Application* and any supporting submissions on all parties to the appeal. You must also file the *Application* and a *Statement of Service* with the Commission.

Any party to the appeal may support or object to this *Application* by filing written submissions with the Commission within **10 days** of being served with the *Application*. The submissions must include the party's reasons why the applicant should, or should not, be permitted to participate. You must serve a copy of the written submission on the representative of the person making the *Application for Intervention*, or, if not represented, on the person seeking to intervene. You must then file a *Statement of Service* with the Commission.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c. I.8, as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Financial Services Commission.

Appeal Case

Appellant

Respondent

Appeal file number

Applicant

Company name **OR** Last name

First name

Middle name

Mr
Mrs
Ms

Street address

City

Province

Postal Code

Home phone number ( )

Work phone number ( )

Fax number ( )

Electronic mail address

Applicant's Representative

Last name

First name

File reference number

Mr
Mrs
Ms

Title

Firm name

Street address

City

Province

Postal Code

Work phone number ( )

Fax number ( )

Electronic mail address

Relationship to the Applicant

☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator/ trustee ☐ court appointed guardian ☐ other, specify ▶

Form K

Application for Intervention

Submissions 1. I seek to intervene in this appeal for the following reasons.

Extra sheets attached

2. I wish to make submissions on the following issues of law. (Include a reference to any statutory provision to be relied on.)

Extra sheets attached

Documents I am relying on the following documents for the Application

Copies of documents are attached

Signature and Certification

I certify that all information in this Application for Intervention and attachments is true and complete. I realize that copies of all information filed with this Application for Intervention will be given to the other parties in this dispute.

Name (please print) Title

Applicant
Representative

Signature Date

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Application for Intervention.

I certify that my representative *(name of representative ▼)*

has full authorization as described above

Applicant Signature Date

Total number of extra sheets attached

1978 (03/01)

Financial Services Commission of Ontario

Dispute Resolution Group

Application for Variation/Revocation

Form L

Use this form to apply for a Variation or Revocation of an Arbitration or an Appeal decision.

An *Application for Variation/Revocation*, instead of a *Notice of Appeal*, is appropriate if the circumstances of the insured person have changed significantly since the hearing, new evidence not available at the arbitration hearing or the appeal, has become available, or there is some clear error in the order (for example, the order does not correspond to the reasons for the decision).

After completing your *Application for Variation/Revocation* form, you must file one copy with the Financial Services Commission of Ontario (the "Commission") at the address below. The steps you must take are set out in this form.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

If you have any questions or want more information, contact:

Appeals Unit
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor, Box 85
North York ON M2N 6L9

In Toronto: (416) 590-7222

Toll Free: 1-800-517-2332, extension 7222

Fax: (416) 590-7077

Commission website: www.fsco.gov.on.ca

Ce formulaire est également disponible en français.

1977 (03/01)

Applying for Variation or Revocation of an Arbitration order or an order of an Appeal Decision

For a complete set of the rules for variations/revocations, see the *Dispute Resolution Practice Code*.

Step 1

Complete this *Application for Variation/Revocation* form. If it is incomplete, it may be rejected. After completing the form, you must serve a copy on the respondent (the other party). If the respondent was represented by a lawyer, you should serve the *Application for Variation/Revocation* on the lawyer. If not, serve the respondent.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the *Dispute Resolution Practice Code*.

Then file the following with the Commission:

- Completed *Application for Variation/Revocation*
- Original *Statement of Service* form stating when and how you served the respondent with the *Application for Variation/Revocation*
- The fee

Step 2

Upon receiving a properly completed *Application for Variation/Revocation*, *Statement of Service* and the application filing fee, the Commission will promptly acknowledge the Application.

Step 3

To oppose your Application, the respondent must file a *Response to Application for Variation/Revocation* within **20 days** of receiving acknowledgement of the *Application for Variation/Revocation* from the Commission. You will get a copy of the *Response to Variation/Revocation* from the respondent.

Step 4

Unless the Director of Arbitrations or an adjudicator delegated by the Director (known as Director's Delegate) advises you differently, your written submissions must be served on the respondent and filed with the Commission within **30 days** of the date the *Response to Variation/Revocation* was due. If a transcript is ordered, this time limit is extended to **30 days** from receipt of the transcript.

Step 5

The Director or Director's Delegate may decide the Variation/Revocation with or without a hearing.

How to Complete the Application for Variation/Revocation

PLEASE PRINT

Decision Details

This information can be found in the arbitration or appeal decision.

Applicant's Name and Address

Fill your name and address as the person or insurance company making this *Application for Variation or Revocation*. Provide any alternative addresses, phone numbers, fax numbers or electronic mail addresses that will make it easier for us to contact you.

Applicant's Representative

You may choose to have someone represent you. Although many people are represented by a lawyer in these proceedings, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the proceeding. A minor (a person under the age of 18) or a person who has been declared mentally incapable, must have a representative.**

Reasons for the Application

Briefly state what part(s) of the Arbitration or Appeal decision you want varied or revoked and the reasons for your request. Attach extra sheets if necessary. Your *Application for Variation/Revocation* must be sufficiently detailed to allow the other party to respond. It is not necessary, however, for you to file your complete written submissions until later.

Action Sought

Briefly state the remedy or outcome you are seeking in your *Application for Variation/Revocation*.

Transcript

Indicate if the hearing was recorded by a reporting service. If it was recorded, indicate if you have ordered a transcript of the hearing. If you do not intend to order a transcript, you must state why a transcript is not needed for the Application.

Evidence

If you want to rely on any additional or new evidence in your Application for Variation or Revocation, you must identify the new evidence and explain why it should be allowed. This should include whether the evidence could have been presented at the hearing and whether it would have led the adjudicator to a different decision.

The Director's Delegate will have access to the Arbitration exhibits and, therefore, it is not necessary to refile them.

This issue may be decided without further submissions so your explanation should be as detailed as possible.

Preliminary or Interim Order of an Adjudicator

The usual rule is that a party may not apply to vary or revoke a preliminary or interim order of an adjudicator. If you are seeking to vary of revoke an interim or preliminary order, you must explain why the usual rule should not apply.

It is likely that this issue will be decided without further submissions, so your reasons should be as complete as possible.

Signature

Sign the form and return it to the Appeals Unit at the Commission.

Fee

If you are an insured person, be sure to enclose the filing fee of $250 by cheque or money order made out to the **MINISTER OF FINANCE. The Application will be rejected if the filing fee is not enclosed.**

If you are an insurer, the Commission will invoice your company for the filing fee (**$250**) and the insurer assessment (**$500**).

Note: You may settle your dispute with the respondent directly at any time during the appeal process.

1977 (03/01)

Ontario

Financial Services Commission of Ontario

Dispute Resolution Group

Application for Variation/Revocation

Form L

Commission file number

Complete ALL sections. Attach extra sheets if necessary.

Decision Details

Applicant | Insurer(s)

Date of Decision | Adjudicator | Arbitration or Appeal file number

Applicant

Company name **OR** Last name | First name | Middle name

☐ Mr. ☐ Mrs. ☐ Ms.

Street address | City | Province | Postal Code

Home phone number ( ) | Work phone number ( ) | Fax number ( ) | Electronic mail address

Applicant's Representative

Last name | First name | File reference number

☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to the Applicant

☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator/ trustee ☐ court appointed guardian ☐ other, specify ▶

Reasons for the Application for Variation/ Revocation

Briefly explain the reasons for your Application.

☐ Extra sheets attached

Actions Sought from the Variation/ Revocation

Briefly explain what outcome or result you are looking for in the Application.

☐ Extra sheets attached

1977 (03/11)

Form L
Application for Variation/Revocation

Transcripts

Was the hearing recorded? No Yes

Are you ordering a transcript of the hearing? No Yes

If Yes, you must inform the other party and arrange for a transcript copy to be provided to him/her and the Director's Delegate. State when you expect to receive the transcript. ▼

If No, briefly explain why a transcript is not needed for the Variation/Revocation. ▼

Extra sheets attached

Preliminary or Interim Order of an Adjudicator

Are you asking for a Variation/Revocation of a Preliminary or Interim Order of an Adjudicator?

No Yes If Yes, briefly explain why you should be permitted to vary or revoke a preliminary or interim order. Your reasons should be as complete as possible. ▼

Extra sheets attached

Evidence

List any evidence that you intend to rely on that was not part of the hearing. Explain why this evidence is necessary. Your explanation should be as complete as possible.

Extra sheets attached

Signature and Certification

I certify that all information in this Application for Variation/Revocation and attachments is true and complete. I realize that copies of all information filed with this Application for Variation/Revocation will be given to the other party in this dispute.

Name (please print) Title

Applicant
Representative

Signature Date

Cheque or money order enclosed

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Application.

I certify that my representative *(name of representative ▼)*

has full authorization as described above

Applicant Signature Date

Total number of extra sheets attached

1977 (03/01)

Financial Services Commission of Ontario
Dispute Resolution Group

Response to Application for Variation/Revocation
Form M

Use this form if you want to oppose an *Application for Variation/ Revocation* filed by the other party to the arbitration or appeal.

You must file this *Response to Application for Variation/Revocation* form with the Commission (address below) **within 20 days** of receiving confirmation of the *Application for Variation/Revocation* from the Commission. The Director of Arbitrations may extend the time limit based on the reasons for the delay and the apparent strength of the Response. The steps you must take are set out in this form.

Personal information requested on this form is collected under the authority of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

If you have any questions about this application, or want more information, contact:

Appeals Unit
Dispute Resolution Group
Financial Services Commission of Ontario
5160 Yonge Street, 15th Floor, Box 85
North York ON M2N 6L9

In Toronto: (416) 590-7222

Toll Free: 1-800-517-2332, extension 7222

Fax: (416) 590-7077

Commission website: www.fsco.gov.on.ca

Ce formulaire est également disponible en français.

1852 (03/01)

For a complete set of the rules for a variation/revocation see the Dispute Resolution Practice code.

Responding to an Application for Variation/Revocation

Upon receiving a properly completed *Application for Variation/Revocation*, the Commission will promptly acknowledge the application by sending letters to all parties to the original arbitration or appeal.

If you want to oppose the variation/revocation, you must respond within **20 days** of receiving confirmation of the application from the Commission. The Director of Arbitrations can extend the time limit based on the reasons for the delay and the apparent strength of the Response.

Step 1

Complete this *Response to Application for Variation/Revocation* form.

After completing the form, you must serve a copy on the applicant. If the *Application for Variation/Revocation* shows that the applicant is represented, you must also serve the representative.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the *Dispute Resolution Practice Code*.

Then file the following with the Commission:

- Completed *Response to Application for Variation/Revocation*.
- Original *Statement of Service* form stating when and how you served the applicant with the *Response to Application for Variation/Revocation*.

Fee

If you are an insured person, there is no fee for filing a *Response to Application for Variation/Revocation*.

If you are an insurer, the Commission will invoice your company the insurer assessment (**$500**).

Step 2

When you receive the applicant's written submissions, your written submissions must then be served on the applicant and filed with the Commission within **20 days**.

Step 3

The Director of Arbitrations or adjudicator delegated or appointed by the Director (known as Director's Delegate), may decide the *Application for Variation/Revocation* with or without a hearing.

How to Complete the *Response to Application for Variation/Revocation*

Please print.

Applicant for Variation/Revocation

This information can be found in the *Application for Variation/Revocation*.

Respondent's Name and Address

Fill in completely. Provide any alternative addresses, phone numbers or fax numbers that will make it easier for us to contact you.

Respondent's Representative

You may choose to have someone represent you. Although many people are represented by a lawyer in these proceedings, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please state the name of the firm. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the proceeding. A minor (a person under the age of 18) or a person who has been declared mentally incapable, must have a representative.**

Response to Application for Variation/Revocation

Briefly state your response to the reasons for variation/revocation set out in the *Application for Variation/Revocation*. Attach extra sheets if necessary. Although you should state your position, it is not necessary for you to file your complete written submissions until later.

Response to Preliminary Matters

Provide your response to the preliminary matters raised in the *Application for Variation/Revocation* (transcript, preliminary or interim order, new evidence). The Director or Director's Delegate may decide the preliminary matters without further submissions so your response should be set out in detail. Attach extra sheets if necessary.

Transcript

If the applicant does not intend to order a transcript, you may state whether you think a transcript is needed for the Response.

Preliminary or Interim Order

The usual rule is that a party may not vary or revoke a preliminary or interim order of an adjudicator. If you object to the Variation/Revocation of a preliminary or interim order, you must explain your objection.

Evidence

The Director or Director's Delegate will have access to the arbitration exhibits and therefore, it is not necessary to refile them.

If you want to rely on any additional or new evidence – documents or witnesses – you must explain what the evidence is and why it should be allowed.

If you object to the introduction of new evidence, you should explain why you object.

This issue may be decided without further submissions so your explanation should be as detailed as possible.

Signature

Sign the form and return it to the Appeals Unit of the Commission.

Note: You may settle your dispute with the applicant directly at any time during the arbitration process.

1852 (03/01)

Financial Services Commission of Ontario

Dispute Resolution Group

Response to Application for Variation/Revocation

Form M

Complete ALL sections.
Attach extra sheets if necessary.

Variation/Revocation file number
P-

Applicant for Variation/ Revocation

Company name **OR** Last name | First name | Middle name
☐ Mr. ☐ Mrs. ☐ Ms.

Respondent's name and address

Last name | First name | Middle name
☐ Mr. ☐ Mrs. ☐ Ms.

Street address | City | Province | Postal Code

Respondent's Representative

Last name | First name | File reference number
☐ Mr. ☐ Mrs. ☐ Ms.

Title | Firm name

Street address | City | Province | Postal Code

Work phone number ( ) | Fax number ( ) | Electronic mail address

Relationship to the insured person

☐ lawyer ☐ para legal ☐ parent with whom the child resides ☐ spouse or family relation ☐ executor/ administrator trustee ☐ court appointed guardian ☐ other, specify ▶

Response to Application for Variation/ Revocation

Briefly explain your response to the Applicant's reasons for variation/revocation.

☐ Extra sheets attached.

1662 (03/01)

Form M

Response to Application for Variation/Revocation

Response to Preliminary Matters

Set out your response to the preliminary matters raised in the **Application for Variation/Revocation** (transcript, preliminary or interim order, new evidence). *See instruction sheet for details.* **Your response should be as complete as possible.**

Extra sheets attached

Signature and Certification

I certify that all information in this Response to Application for Variation/Revocation and attachments is true and complete. I realize that copies of all information filed with this Response to Application for Variation/Revocation will be given to the other party in this dispute.

Name (please print) | Title | Respondent Representative

Signature | Date

If your representative is NOT a lawyer, please certify that you have provided your representative with full authorization to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute, on your behalf in connection with this Appeal.

I certify that my representative (name of representative ▼)

has full authorization as described above

Respondent Signature | Date | **Total number of extra sheets attached**

1852 (03/01)

Financial Services Commission of Ontario
Dispute Resolution Group

Summons to Witness

Form N

This form is in quadruplicate.
Page 1 – Witness
Page 2 – Commission
Page 3 – Insurance company
Page 4 – Insured person.

*This summons must be served at least **5 business days** before the first day of the hearing set out below. An adjudicator may order a shorter period of time for service. If so, a copy of the order setting out the shorter time for service must be served with this summons.*

Insurance Act*, R.S.O. 1990, Chapter I.8 as amended *(the "Act")

SUMMONS TO A WITNESS BEFORE the Financial Services Commission of Ontario

Re: *(Parties)* Commission File No. A -

TO: *(name and address of witness)*

For oral hearing

YOU ARE REQUIRED TO ATTEND TO GIVE EVIDENCE at the hearing of this proceeding

on, _____ (*day*), _____ (*date*), at _____ (*time*), _____ (*place*),

and to remain until your attendance is no longer required.

YOU ARE REQUIRED TO BRING WITH YOU and produce at the hearing the following documents and things:
(Set out the type and date of each document and give sufficient particulars to identify each document and thing. Attach extra sheets as required.)

Additional sheets attached. ☐

IF YOU FAIL TO ATTEND or to remain in attendance as this summons requires, the Ontario Superior Court of Justice may order that a warrant for your arrest be issued, or that you be punished in the same way as for contempt of that court.

For electronic hearing

YOU ARE REQUIRED TO PARTICIPATE IN AN ELECTRONIC HEARING

on, _____ (*day*), _____ (*date*), at _____ (*time*),

in the following manner: *(Give sufficient particulars to enable witness to participate.)*

IF YOU FAIL TO PARTICIPATE IN THE HEARING in accordance with the summons, the Ontario Superior Court of Justice may order that a warrant for your arrest be issued, or that you be punished in the same way as for contempt of that court.

Signature

_____ *Financial Services Commission of Ontario*
Office of the Registrar

_____ *Date*

Note: You are entitled to be paid the same fees or allowances for attending at or otherwise participating in the hearing as are paid to a person summoned to attend before the Ontario Superior Court of Justice. Refer to the attached Practice Note 8 for further information concerning this summons.

Ce formulaire est également disponible en français.

1858 (03/01)

Financial Services Commission of Ontario

Dispute Resolution Group

Affidavit of Service for a Summons to Witness

Form O

This is a three part form.
White - Financial Services Commission of Ontario
Yellow - Insurance Company
Pink - Insured Person

The purpose of this Affidavit is to verify that a copy of the document named was personally served on the named person.
An *Affidavit of Service for a Summons to Witness* must be prepared for service of a Summons.

Case Information

Insured Person	Insurance Company	Commission file number

Declaration

I, _____ (Full Name),

of the _____ (City, Town, etc.) of _____ (Name of City, Town, etc.)

in the _____ (County, Regional Municipality, etc.) of _____ (Name of County, Regional Municipality)

SWEAR OR SOLEMNLY AFFIRM THAT:

(1) At _____ (Time) a.m./p.m. on _____ (Day of Week), the _____ (Date) of _____ (Month), 20 _____ (Year),

I personally served _____ (Name of person served)

with a copy of _____ (Name of document served)

at _____ (Location where document was served).

(2) I was able to identify the person by _____ (State means of identification).

(3) For a *Summons to Witness*, I paid the appropriate attendance monies to the person served, named above.

Signatures

Sworn (or Solemnly Affirmed) before me at the _____ (City, Town, etc.) of _____ (Name of City, Town, etc.)

in the _____ (County, Regional Municipality, etc.) of _____ (Name of County, Regional Municipality)

on this _____ (Date) of _____ (Month), 20 _____ (Year).

_____ Signature of Commissioner of Oaths

_____ Signature of Person Serving

Ce formulaire est également disponible en français.

1858 (03/01)